14453 SE 29th Street Suite D
Choctaw, OK 73020
(405) 741-2844

Date: ________________________

Name of person completing this form: _____________________________ Child's Legal Name: ________________________________

Child's Date of Birth: ____________ Sex: _____ Gender: _____ Address: ____

Preferred Phone: ______________________ Home Cell Email Address: ____

Is the child adopted? Yes No If yes, are they aware? Yes No Race: _______________ Religion: ___________________

Who lives in the same household as the child?

Name	Sex	Age	Relationship to Child

Parent(s) occupation: ___________________________________ Who referred you to us? _____________________________________

What are the main concerns that you have about your child?

____

____

____

How long have you had these concerns?

____

What are your goals for treatment of your child?

____

Please check all of the following symptoms that apply to your child:

Sad or depressed mood	Drastic mood swings	Hearing voices that other people cannot hear	Making involuntary sounds
Withdrawn from family/friends	Episodes of decreased *need* for sleep	Seeing things other people cannot see	Easily loses temper
Loss of interest in activites/hobbies	Extreme hyperactivity	Feeling paranoid	Easily annoyed
Feelings of guilt/worthlessness	Racing thoughts	Odd thinking or beliefs	Defiant
Feeling hopeless about the future	Talking so fast it's hard to understand	Thoughts, feelings or pictures that come into the child's mind even if they do not want them to	Argues with authority figures
Sleep disturbance	Overly happy/euphoric	Habits the child feels they must do even if they know it doesn't make sense (excessive cleaning, counting)	Annoying others on purpose
Change in appetite	Overly confident	Poor body image	Blaming others for their mistakes
Low energy/fatigue	Worrying too much	Trying to lose weight even though they are not overweight	Resentful, spiteful or vindictive
Trouble focusing/concentrating	Feeling/acting restless	Intentionally throwing up after eating	Lying
Thoughts of hurting self	Muscle tension	Difficulty learning	Stealing
Thoughts of suicide	Panic/anxiety attacks	Trouble understanding social cues	Destroying property
Thoughts of hurting/killing others	Fear of looking stupid/being embarrassed	Being very sensitive to sound, light, touch or smell	Setting fires
Irritability	Fear of offending others	Difficulty forming/keeping friendships	Skipping school
Severe angry outbursts	Any other fears/phobias	Tics, twitches or involuntary movements	Hurting other people or animals

Has your child ever been exposed to actual or threatened death, serious injury, or sexual violence? Yes No

If yes, do they have any of the following symptoms related to the traumatic event? (Please check)

Upsetting or intrusive memories	Avoiding talking or thinking about what happened
Nightmares	Feeling upset by reminders of the event
Flashbacks (feeling or acting like the event is happening again)	Having out of body experiences
Feeling like the world/surroundings are not real	Getting startled very easily
Angry outbursts	Always looking around for signs of danger
Recklessness or self-destructive behavior	Trouble remembering some or all of what happened

Has your child ever seen a **psychiatrist or therapist/counselor** before?

Name of provider	Dates seen	Reason

Has your child ever been admitted to a **psychiatric hospital**?

Name of the hospital	Dates	Reason

Has your child ever attempted suicide? Yes No If yes, please describe: ____

____

Does your child engage in any self-harm behaviors (e.g. cutting, burning)? Yes No If yes, please describe: ____________________

____

Has your child ever been violent or aggressive? Yes No If yes, please describe: ____

____

Family History

Please mark any known psychiatric illnesses in **blood relatives** of the child:

Psychiatric illness	Child's Mother	Child's Father	Child's Siblings	Mother's Family	Father's Family
Depression					
Anxiety					
Bipolar disorder					
Psychosis					
Schizophrenia					
ADHD					
Intellectual disability or learning problems					
Autism					
Eating disorder					
Alcohol problems					
Drug problems					
Suicide					

Does the child have any blood relatives with heart defects or arrhythmias? Yes No Unknown

Does the child have any blood relatives who died suddenly at a young age? Yes No Unknown

Substance Use History

Does the child use alcohol, tobacco, illegal drugs or abuse prescription drugs? If yes, please specify: ___________________________

____

Medical History

Describe any allergies the child has (e.g. to medications, foods)

___

Does your child have any history of the following medical conditions? (Please check all that apply)

Asthma	Convulsions/Seizures/Epilepsy	Loss of Consciousness	Low Blood Pressure
Respiratory Problems	Head Injury	Heart Problems	Urogenital Problems
Diabetes	Dizziness or Fainting	High Blood Pressure	Vision Problems
Hearing Problems	Dental Problems	Cancer	Skin Problems

Any other serious illness or disease? ___

Has your child ever had surgery? Yes No If yes, please describe and give dates: ___

___

Has your child ever had any serious injuries? Yes No If yes, describe and give dates: ___

___

Biological females only:

Has your child started menstruation? Yes No If yes, at what age: ____ Are periods regular? Yes No

Date of last cycle: ___ Is there any change in symptom severity with periods? Yes No If yes, please describe:

___

Please attach a list of all medications, herbals, and supplements your child is currently taking. Include dosage and prescriber.

Please check any medications your child has taken **in the past**:

Alprazolam (Xanax)	Desipramine (Norpramin)	Lisdexamfetamine (Vyvanse)	Sertraline (Zoloft)
Amitriptyline (Elavil)	Desvenlaxine (Pristiq)	Lithium	Topiramate (Topamax)
Amphetamine (Adderall)	Dexmethylphenidate (Focalin)	Lorazepam (Ativan)	Trazodone (Desyrel)
Aripiprazole (Abilify)	Diazepam (Valium)	Loxapine (Loxitane)	Valproic Acid (Depakote)
Asenapine (Saphris)	Deloxetine (Cymbalta)	Lurasidone (Latuda)	Venlafaxine (Effexor)
Atomoxetine (Strattera)	Escitalopram (Lexapro)	Methylphenidate (Aptensio, Concerta, Daytrana, Metadate, Methylin, Ritalin, Quillivant)	Vilazodone (Viibrid)
Bupropion (Wellbutrin)	Fluoxetine (Prozac)	Mirtazapine (Remeron)	Vortioxetine (Brintellix)
Buspirone (BuSpar)	Fluphenazine (Luvox)	Nortriptyline (Pamelor)	Ziprasidone (Geodon)
Carbamazepine (Tegretol)	Guanfacine (Intuniv)	Olanzapine (Zyprexa)	Other:
Citalopram (Celexa)	Haloperidol (Haldol)	Oxcarbazepine (Trileptal)	Other:
Clomipramine (Anafranil)	Iloperidone (Fanapt)	Paliperidone (Invega)	Other:
Clonazepam (Klonopin)	Imipramine (Tofranil)	Paroxetine (Paxil)	Other:
Clonidine (Kapvay)	Lamotrigine (Lamictal)	Quetiapine (Seroquel)	Other:
Clozapine (Clozaril)	Levomilnacipran (Fetzima)	Risperidone (Risperdal)	Other:

Social History

Name of child's current school: ___

Current grade: ___ Did the child repeat any grades? Yes No ___

Does the child have a 504 plan or IEP? Yes No ___

Is the child in ESE or special needs classes? Yes No ___

Has the child ever been suspended or expelled? Yes No ___

Does the child get bullied by peers? Yes No ___

Has the child ever been the victim of abuse? Yes No ___

Has the child been arrested? Yes No ___

Are there any weapons or guns in your home? Yes No ___

Does your child have access to them? Yes No ___

Developmental History

(Not all parents remember the answers to these questions. You can write down what you do remember or look back if you kept a baby book.)

What was the length of the pregnancy? ____

Were any medications or substances used during pregnancy? Yes No If yes, please describe: ______________________________

____

Any other complications of pregnancy or delivery? Yes No ____

How much did the baby weigh at birth? _________ Did the baby start breathing right away? Yes No ________________________

Were there any problems with the baby after he/she was born? Yes No ____

When did the baby leave the hospital? ____

When the baby came home, were there any problems? Yes No ____

When did the baby really smile (not "gas")? ___________ When was the baby able to sit by themselves (without help)? __________

When did the baby walk by themselves (without holding on)? ____________ When did baby say their first word? ________________

When did the baby say short sentences (such as "go bye bye")? ____

Did the child have trouble learning to speak? ____

Were they different from brother or sister or other children? ____

Is the child toilet trained? Yes No If yes, how old when trained? ____

When did the child learn to ride a tricycle? ____

When did the child learn to ride a bicycle without training wheels? ____

When was the child able to get dressed by themselves? ____

When was the child able to tie shoelaces?____

What hand does the child prefer to use? Right Left No Preference At what age did you notice this? ____________________

Did anything else significant occur during the child's development years?

____

____

Testing History

Did the child ever have IQ or achievement testing? Yes No ____

Has the child been tested for hearing abnormalities? Yes No ____

Has the child been tested for speech/language abnormalities? Yes No ____

Has the child ever received occupational or physical therapy? Yes No ____

Has the child experienced any of the difficulties below? (Please check all that apply):

Death of a parent	Death of other loves ones/close friend	Separation from parent or family
Parent separation/divorce	Loss of home	Family financial problems
Parent with substance abuse problem	Conflicts with parents	Removal of child from home
Victim of crime or violence	Unwanted pregnancy	School problems
Illness in self	Illness in family	Other:

I certify that the information I have provided on this form is accurate to the best of my knowledge.

_______________________________________ _______________________________

Legal Guardian Signature Date

_______________________________________ _______________________________

Printed Legal Guardian Name Printed Patient Name

INFORMED CONSENT FOR TREATMENT AND/OR OTHER SERVICES CONTRACT

Welcome to the practice. This document contains important information about the professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them. By signing this document, you certify that you have read it in its entirety (six pages), understand it, agree with and will abide by each provision.

IMPORTANT

- For their safety, children under the age of 13 cannot be left alone in the waiting room. Parents/Guardians are ultimately responsible for the safety of their children, including those 13 or older when left in the waiting room unsupervised.
- For everyone's safety, firearms, knives or other weapons are not allowed on the premises.
- To keep our office clean: no food or drink (other than water or food for babies) are allowed inside the building.
- Regarding substances: smoking and vaping are not allowed within 30 feet of our office, and no illicit drugs or alcohol are allowed on the premises.

THERAPY SERVICES

Psychotherapy varies depending on the personalities of the clinician and patient and the particular problems you hope to address. There are many different methods we may use in therapy. Psychotherapy calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about during our sessions and at home. Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, although there are no guarantees as to what you will experience, psychotherapy has also been shown to have benefits for people who go through it. If you have concerns about working with us, it is important that we discuss them. However, to best meet your needs, we are always willing to facilitate a referral to another mental health professional. The same is true if we believe we are not the best office to meet your needs. Therapy typically consists of a once-weekly 50-minute session, but could occur more or less often depending on circumstances. Note: We cannot guarantee that you will be given appointments on a same day or same time basis.

TESTING, ASSESSMENTS AND EVALUATIONS

Occasionally during counseling/medication management sessions we will administer brief testing. Most often, evaluations are a 2-3 hour initial session with an assessor followed by a results session after the timely return of all the required assessments. Please see the Testing Agreement for more information. Important: Your insurance statements may show services on a date when you or your child were not in the office. This is because we are allowed to charge for test scoring, interpretation and report writing. You will be responsible for co-pays as directed by your insurance.

MEDICATION MANAGEMENT

Medication management is a separate service from therapy and testing offered at our office. The physician assistant who provides this service is capable of managing all psychiatric medications and offers goal-focused counseling during sessions. This is intended to aid in reducing or eliminating unwanted symptoms, to help you or your child achieve greater psychological comfort, to improve behavioral functioning and/or self control and achieve better adjustment to life circumstances. Not all cases are best managed by our provider so we will refer potential clients to more extensive psychiatric services as needed.

MEETINGS, PROFESSIONAL FEES, BILLING AND PAYMENTS

The hourly fee for therapy is $100. The hourly fee for testing is $125. The hourly fee for medication management is $120. You will be expected to pay for each service at the time it is given unless we agree otherwise, or unless you have insurance covering the services provided. Payments include but are not limited to self-pay, **co-pays**, **deductibles**, no shows and/or late cancellation fees. We reserve the right to charge a $65 no-show fee or late cancellation fee to the card on file, unless certain circumstances apply, as well as a $50 fee for returned checks. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, we will attempt to charge the card on file, then use legal means and/or collections. If these actions are necessary, their costs will be included in the claims. In most situations, the only information we will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided and the amount due.

If you have a health insurance policy, it will usually provide coverage for mental health treatment. However, you (not your insurance company) are responsible for the full payment of fees. ***You understand and agree that it is your responsibility to obtain any preauthorization of services required by your insurance—even if we have contacted your insurance and receive authorization or have attempted to receive authorization. If you do not obtain preauthorization and it is required by your insurance, you acknowledge that you are responsible for payment.*** Although we will do our best to determine if your insurance covers our services, we cannot guarantee coverage or continued coverage. Please read your insurance coverage information and call your plan administrator if you have any concerns about payment. You should also be aware that most insurance companies require that we provide them with your clinical diagnosis, but sometimes we are required to provide additional clinical information, such as treatment plans, progress notes, summaries or copies of the entire record (in rare cases). We cannot guarantee that your insurance company will keep your records confidential. Please call your plan administrator if you have any concerns. ***By using your insurance, you authorize us to release such information to your insurance company.***

If you become involved in legal proceedings that require our participation, you will be expected to pay for any professional time the provider spends on your legal matter, even if the request comes from another party. In the case of parenting and/or child issues, if we are required to testify, we will **NOT** give an opinion about either parent's custody, visitation, suitability, or fitness. If the court appoints a custody evaluator or *guardian ad litem* (GAL), we will only provide information if appropriate releases are signed or a court order is provided. Phone calls with a GAL will be charged at a rate of $50 per 30 minutes. If a provider is required to appear as a witness or perform work related to any legal matter, the party responsible for their participation agrees to reimburse them at the rate of $250 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance and/or any other case-related costs. **Important**: Your insurance will *not* cover legal services or fees.

COMMUNICATION

Regular business hours are M-Th from 8:00 a.m. – 5:00 p.m. We are closed on Friday unless you have a special arrangement. If you are unable to reach us and there is an emergency (i.e. thoughts of suicide/homicide/self-harm) you must call 911 or go to the nearest emergency room. The providers are often not immediately available by telephone. The phone is answered by office staff who work during regular business hours or voice mail. Our office will make every effort to return your call within 24 hours with the exception of weekends and holidays. We highly recommend scheduling an appointment for anything you would like to discuss with a provider as their schedules do not allow for returning phone calls directly. We have a separate voicemail specifically for medication refill requests as our administrative staff does not have the training to help with these requests. We request you leave **one message per request** for the provider to handle. Multiple messages will increase the time it takes for your request to be handled. We do have an email that the administrative staff manages during regular business hours as a secondary communication option. This email address is poynermentalhealthservices@protonmail.com and is HIPAA compliant. We will use this email to send paperwork and discuss scheduling and billing topics as needed. We do not communicate via social media with patients, nor do we respond to this type of communication from anyone in treatment with one of our providers. When you provide this office with a telephone number and/or email, you are giving the staff permission to contact you and/or leave a voicemail, unless you state otherwise in writing. In addition, you give us permission to fax or electronically transmit billing and/or collections information. Finally, you give the staff permission to fax information you have approved with a signed release of confidentiality (such as records) or is mandated by an outside entity (i.e. legal or protective services). We reserve the right to charge ten cents per page of copied material.

ACCESS AND STORAGE OF RECORDS AND ELECTRONIC HEALTH INFORMATION

Your records are stored in the following manners: Paper file that is stored in a locked office in a locked file cabinet and/or in an electronic file that is protected by encryption.

DRIVING IMPAIRMENT

We respectfully request that you be free of alcohol or other intoxicants prior to to the office. If, during the session, the provider comes to suspect that your senses are impaired in any way, we will address that concern to determine if we can continue the appointment. If, in fact, you are "intoxicated" for whatever reason, the session will end and the provider or office staff will attempt to make arrangements for safe transportation from the office (i.e. calling a relative, friend, emergency contact, or calling a taxi cab). If, for some reason, you refuse to cooperate, then we have the option to contact the police in order to ensure your safety and the safety of others. In the event that an appointment is ended due to suspected intoxication, the full fee for the session will be due, regardless of the actual duration of the session. If we have realistic concerns related to your ability to drive safely because of, but not limited to, mental illness, dementia or a medical problems, we reserve the right to contact the Department of Public Safety in that regard.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a clinician is protected by law. Releasing information requires your written permission except in certain circumstances. If a judge orders a provider's testimony or records, we must comply. We are legally required to take protective actions if we believe that a child, vulnerable adult or elderly person is being abused or has

been abused, or if we believe a person has the intention or plan to hurt themselves or another person. These actions may include notifying a state agency and/or a potential victim and/or contacting the police and/or seeking inpatient care. However, we will attempt to fully discuss it with you before taking any action.

You should be aware that the practice employs multiple health professionals including administrative staff. In most cases, we need to share protected information with these individuals for both clinical (consultation with clinicians only) and administrative staff for such services as scheduling, billing and quality assurance. During a consultation, we make every effort to avoid revealing the identity of the patient, and any clinician consulted is also legally bound to keep the information confidential. Ordinarily, we will not tell you about these consultations unless we believe that it is important to our work together. All clinicians and staff members will be given training about protecting your privacy and will agree not to release any information outside of the practice without the permission of a professional staff member.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns you. We will be happy to discuss these issues with you and provide clarification upon your request. However, if you need specific clarification or advice we are unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex.

PARENT AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify the office immediately. You must provide the office with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child. You must furnish signed copies of this Informed Consent by both custodial parents for our office to be able to schedule your child as a new client. If you are separated or divorced from the child's other parent, please be aware that we may find it necessary to contact the other parent and advise them of appointments with your child.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the provider regarding the child's treatment. If such disagreements occur, the provider will listen carefully so that they can understand your perspectives and fully explain their perspective. Ultimately, parents decide whether treatment will continue. If either parent decides that treatment should end, we will honor that decision unless there are extraordinary circumstances. However, in most cases, we will ask that you allow me the option of having a few closing appointments with your child to appropriately end the treatment relationship.

In the course of treatment of your child, the provider may meet with the child's parents/guardians separately or together. Note: the patient is your child – not the parents/guardians/siblings/other family members of the child. If the provider meets with you or other family members in the course of your child's treatment, they may document the meeting in your child's treatment records. Please be aware that progress notes will be available to any person or entity that has legal access to your child's treatment record. In some situations, we are required by law or by the guidelines of governing boards to disclose information, whether or not the provider has you or your child's permission. We have listed some of these situations below.

Confidentiality ***cannot be maintained*** when:

- A child tells the provider they plan to cause serious harm or death to themselves, and they believe the child has the intent and ability to carry out this threat in the very near future. The provider must take steps to inform a parent or guardian or others of what the child has told them and how serious they believe this threat to be and to try to prevent the occurrence of such harm.
- A child tells the provider they plan to cause serious harm or death to someone else, and they believe the child has the intent and ability to carry out this threat in the very near future. In this situation, the provider must inform a parent or guardian or others, and they may be required to inform the police and/or the person who is the target of the threatened harm.
- A child is doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, the provider will need to use their professional judgment to decide whether a parent or guardian should be informed.
- A child tells the provider, or they otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, the provider is required by law to report the alleged abuse to the appropriate state child-protective agency.
- The provider is ordered by a court to disclose information.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS

Treatment is most effective when a trusting relationship exists between the clinician and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. It is office policy to provide you with general information about your child's treatment, but not to share specific information your child has disclosed to the provider without your child's agreement, unless what is shared puts the child in danger. You can always ask the provider questions about the types of information they would disclose. Even when we have agreed to keep your child's treatment information confidential from you, the provider may believe that it is important for you to know about a particular situation that is going on in your child's life. As such, when meeting with you, the provider may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

PARENT/GUARDIAN AGREEMENT NOT TO USE MINOR'S THERAPY INFORMATION/RECORDS IN CUSTODY LITIGATION

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although the provider's responsibility to your child may require helping to address conflicts between the child's parents, the provider's role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena records or ask the provider to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing their opinion about any matter related to you or your child. However, your agreement may not prevent a judge from ordering the provider's testimony. If the provider is required to testify, they are ethically bound not to give their opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a GAL or Child Protective Services is involved, the provider may be compelled to release information.

NOTICE OF POLICY AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION (PHI)
Health Insurance Portability and Accountability Act (HIPAA)

This notice describes how mental health and medical information about you may be used and disclosed and how you can obtain access to this information. **Please review this policy carefully.**

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

We may use or disclose your Protected Health Information (PHI) for treatment, payment and healthcare operations and purposes with your consent. To help clarify these terms, here are some definitions:

a. "PHI" refers to information in your health record that could identify you.
b. Treatment, Payment and Health Care Operations:
   - "Treatment" is when the provider provides, coordinates or manages your health care and other services related to your health. An example of treatment would be when the provider consults with another health care provider, such as your family physician, primary care physician or another clinician.
   - "Payment" is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
   - "Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of Health Care Operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination.
c. "Use" applies on to activities within the office/practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
d. "Disclosure" applies to activities outside the office/practice such as releasing, transferring or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse or Neglect: If the provider has reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that the provider makes a report to the appropriate government agency, usually to the Department of Human Services. Once such a report is filed, the provider may be required to provide additional information.
- Adult or Domestic Abuse: If I have reason to believe that a vulnerable adult is suffering from abuse, neglect or exploitation, the provider is required by law to make a report to either the Oklahoma Department of Human Services, the District Attorney's office or the Municipal Police Department as soon as the provider becomes aware of the situation. A vulnerable adult means an individual who is an incapacitated person who, because of physical or mental disability, incapability or other disability, is substantially impaired in the ability to provide adequately for the care or custody of him/herself, or is unable to

manage his/her property and financial affairs effectively, or to meet essential requirements for mental or physical health or safety, or to protect him/herself from abuse, neglect or exploitation without assistance from others.

- Health Oversight: If you file a disciplinary complaint against your provider with the Oklahoma State Board of Examiners of Psychologists, Oklahoma State Board of Mental Health, or the Oklahoma Medical Board, they would have the right to view your relevant confidential information as part of the proceedings.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnoses and treatment and records thereof, such information is privileged under State law and we will not release the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health and Safety: If you communicate to the provider an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, the provider has the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records, which is essential to protect the rights and safety of others. The provider also has such a duty if you have a history of physical violence of which they are aware, and they have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.
- Worker's Compensation: If you file a Worker's Compensation claim, you will be giving permission for the Administrator of the Worker's Compensation Court, the Oklahoma Insurance Commissioner, Attorney General or District Attorney (or a designee for any of these) to examine your records relating to the claim.
- Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as text messages, emails or letters).
- Agency Review: As an agency contracted with the State of Oklahoma, PHI can be released to the Oklahoma Health Care Authority or Oklahoma Department of Mental Health and Substance Abuse Services for oversight activities as authorized by law, including conducting or arranging for a medical review, auditing functions, including fraud, abuse detection and compliance programs. In addition, our compliance officer conducts periodic quality control audits or institutional reviews which will require access to your records.

III. Patient's Rights and Clinician's Duties

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer (Kim Woodhouse, LPC) at 14453 SE 29th St. Suite D, Choctaw, OK 73020:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of Protected Health Information about you. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:
  You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a counselor at our office. Upon your request, the office will send your bills to another address.)

- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, the office will discuss with you the details of the request and denial process.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. The office may deny your request, but on your request, we will discuss with you the amendment process.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, the office will discuss with you the details of the accounting process.
- Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- Clinician's Duties: We are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices. The office reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect. If we revise our policies and procedures, the office will notify you in writing by mail, or at your next appointment.

IV. Questions and Complaints

If you desire further information about our privacy practices, or if you have questions, please contact this office. If you are concerned that your privacy rights have been violated or you disagree with a decision I made about access to your records, you may contact the Privacy Officer (Kim Woodhouse, LPC) of Poyner Mental Health Services at 14453 SE 29th St. Ste. D Choctaw, OK 73020.

You may also send a written question or complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

V. Effective Date, Restrictions, and Changes to Privacy Policy
This notice will go into effect on January 1, 2024. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. The office will provide you with a revised notice in writing by mail or at your next appointment.

You have the right to services:
- That respect your privacy and dignity; that they are provided in a prompt, courteous and respectful manner;
- That respect your cultural and ethnic identity, religion, disability, gender, age, marital status and sexual orientation;
- That are provided in a physical environment that is safe, sanitary, allows for effective treatment and which safeguards the privacy and confidentiality of interactions with your provider;
- From providers who are qualified, competent, focused on your care, and reasonably accessible to you;
- That emphasize your participation in developing a treatment plan specific to your needs and include your agreement to work toward defined goals;
- That in relation to admission, discharge or treatment, are free of discrimination on the basis of age, sex, race, creed, color, national origin, ethnicity, religion, pregnancy, marital status, disability or sexual orientation.

Rights to Current Information Concerning:
- Your diagnosis, recommended appropriate or medically necessary treatment options that relate to your care, potential alternatives and accompanying risks, benefits and costs (in writing for Medicare patients). This information, regardless of cost or benefit coverage, will be explained in terms and in a language that you can reasonably understand;
- Written financial agreements in which you entered for treatment services rendered;
- Possible consequences or conditions under which you may be transferred to another treatment program or therapist and the accompanying risks, benefits and costs of such a transfer;
- Names and credentials of providers involved in your care;
- Your responsibilities to ensure better treatment outcomes;
- Your records and having information explained or interpreted as necessary, except when protected or restricted by law;
- How to access emergency services needed outside of normal business hours or when you are away from you usual place of residence or work;
- How your healthcare insurance plan evaluates new technology for inclusion as a covered benefit;
- How to select a new behavior healthcare delivery office or provider if your current provider is affected by termination or closure;
- Resources and procedures available through your healthcare insurance plan for communicating concerns or questions, for expressing dissatisfaction with services or care, and for requesting an appeal if not satisfied with any decisions regarding dissatisfaction with services or care;
- Services available to you and charges for those services including services not covered under health plan's benefits.

INFORMED CONSENT FOR TREATMENT AND/OR OTHER SERVICES CONTRACT

Patient Name: _________________________ Guardian: (if patient is a child): ___________________________

The client or responsible party must sign this form before services can begin.

By signing below, I certify that I have read, had any questions answered, fully understand, agree with and will abide by the provisions contained in the entire INFORMED CONSENT FOR TREATMENT AND/OR OTHER SERVICES CONTRACT. If you would like a copy of this document, please let us know.

____ _____________________________________

Patient or Guardian or Authorized Patient Representative Date

Informed Consent for Telehealth Services

Telehealth involves the use of electronic communications to enable Poyner Mental Health Services' mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Poyner Mental Health Services utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to

request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

Poyner Mental Health Services will bill insurance for telehealth services. It is your responsibility to understand if your insurance pays for telehealth. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, prompt payment is expected. Any applicable copays or fees must be paid prior to the session. A fee of $65 will be charged for appointments which are not canceled without 24 hours notice.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Signature Print Name Date

14453 SE 29th Street Suite D
Choctaw, OK 73020
(405) 741-2844

Appointment Reminders

We can now send you appointment confirmation messages and reminders by text message and email. If you wish to receive these messages we require your consent.

If you wish to receive these messages, please read the disclaimer below then complete and sign.

I consent to Poyner Mental Health Services contacting me by text message and email for the purposes of appointment reminders.

I acknowledge that appointment reminders by text and email are an additional service and that these may not take place on all occasions, and that the responsibility of attending appointments or canceling them still rests with me. I can cancel the reminders at any time.

I acknowledge that Poyner Mental Health Services can only have one phone on file for reminders and will **not** be responsible for contacting any other parent/guardians for appointment reminders.

Text messages and emails are generated using a secure platform. I understand that they are transmitted over a public network onto a personal device and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my mobile number or email changes or is no longer in my possession.

Patient Name_________________________________ Date of birth________________________

Name of parent/guardian (If applicable)____

Mobile Number_________________________ Email____________________________________

By signing I agree to all the terms and conditions above.

Signature ______________________________________ Date____________________________

Credit Card Consent Form

Poyner Mental Health Services requires all patients to securely store a form of payment by credit card for all patients. You may still choose to pay by cash, check, HSA, or credit card on the day of your appointment, and your card information will only be kept on file to be used in the case of account balances over 30 days past due or no show/late cancellation fees. Patients who cancel counseling or medication management appointments with less than 24 hours notice, arrive 15 minutes or more past their scheduled appointment, or do not show up for scheduled appointments will be charged a $65 fee. Patients who cancel testing appointments with less than 48 hours notice, arrive 15 minutes or more past their scheduled appointment, or do not show up for the scheduled appointment will be charged a $200 fee.

A fee *WILL* be automatically charged to the card on file if an appointment is not canceled with enough notice.

By signing below, I understand and agree to the terms of this agreement, agree to pay, and specifically authorize the charging of my credit card as stipulated. I further agree that in the event my credit card becomes invalid, I will provide a valid credit card upon request to be charged for the payment of any outstanding balances owed. Delinquent accounts may be sent to collections if a payment plan has not been set up within 30 days of account finalization.

Patient Name: ____

If you would like an unsecured emailed copy of your receipts, please identify the address you would like used below:

____

Last Four Digits of Card Number ___ ___ ___ ___

Name on Credit Card: ____

Signature of Guarantor for Payment: ____________________________ Date: ______________

This credit card authorization will remain in effect and on file with Poyner Mental Health Services unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination.

Please send completed paperwork to this email: poynermentalhealthservices@protonmail.com

14453 SE 29th Street Suite D
Choctaw, OK 73020
(405) 741-2844

Medication Management Agreement

I, ________________________________, understand and voluntarily agree that
(initial each statement after reviewing)

______ I will keep and be on time for all my scheduled appointments with Poyner Mental Health Services. Cancellations and/or no showing my scheduled appointments may result in denial of my prescription until I am seen by my provider.

______ I understand my refill request may take up to 72 hours to process if requested outside of my scheduled office visit. It is my responsibility to schedule follow-up appointments for refills.

______ I understand that some medications are not intended to be taken long term and my provider may recommend to discontinue my controlled substance prescribed by other providers at any time.

______ I understand that I will need to provide an up to date list of any medications I am currently taking.

______ I understand that the provider will respect patient confidentiality and I will share any use of illicit substances and medical marijuana with them to promote safe prescribing practices.

______ I may be asked to complete random urine testing.

______ I understand that some medications require lab monitoring and I will be required to complete labs for the provider to prescribe medications safely.

______ I will treat the staff at the office respectfully at all times. Being disrespectful to staff or disrupting the care of other patients will not be tolerated.

______ I understand that if I violate any of the above conditions, my treatment which includes prescriptions for medications, may be terminated and I will be subject to dismissal from Poyner Mental Health Services.

No patient will be required to take medication and always have the right to either refuse and/or request to be taken-off of any medication at any time.

______________________	______________________	______________________
Patient Name (please print)	Patient Signature	Date
______________________	______________________	______________________
Parent Name/Guardian (please print)	Signature of Parent/Guardian	Date