ODYSSEY WELLNESS

3067 E. Warm Spring Rd., Ste. 100
Las Vegas, NV 89120
O: 702.202.0000
F: 702.710.6521

Consent for Services

Client Name:_____ Date of Birth: _____
(Last) (First) (MI) (Month / Day / Year)
Parent/Guardian Name *(if applicable)*: _____ Email: _____
Address: _____ Phone:_____

Welcome to Odyssey Wellness! We look forward to working with you on your journey to psychological well-being and empowering you to reach your treatment goals.

I. Services Provided

The following information will provide you with insight on business policies and procedures regarding your appointments. It is important to read the following information thoroughly as this document acts as an agreement between you and Odyssey Wellness. In addition, this document provides you with information to make informed decisions regarding your healthcare.

Odyssey Wellness provides several mental health services that include:

- Individual Therapy
- Family Therapy
- Assessments and Evaluations
- Psychological Testing
- Treatment Planning
- Recommendations
- Consultations
- Referrals

Odyssey Wellness is located in an office with other psychologists providing mental health services where professionals at times collaborate on cases, share administrative staff and utilize clinical services of these other professionals in order to provide its clients with the best possible treatment and care.

II. Policies

I authorize Odyssey Wellness, and all doctors, clinicians and staff (collectively referred to as "Provider"), to provide mental health services which may include, but not be limited to: assessments, reassessments, treatment planning, psychotherapy, psychological testing, recommendations, and referrals for myself and/or for the above-named person if the person named above is a minor or an adult who is legally incompetent. I certify that I am the person named above or the legal guardian of such person and have the legal right to approve of these services. ____(initials)

Although the client listed above is the identified patient, I understand that the Provider may work with family members of the above-named person, including, but not limited to: parents, step-parents, siblings, grandparents, spouses, significant others or children of the above-named person. I understand that the Provider may choose to include these individuals in treatment as deemed necessary and that additional consent may be required from each party for such participation. ____(initials)

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I understand that if I am divorced or separated and share joint legal custody with my ex-spouse, she/he must also consent to the provision of services to a minor, and such person is entitled to the information obtained during the child's treatment, including, but not limited to, progress notes, assessments, records received, or a summary letter generated by the Provider detailing treatment. ____(initials

I understand that the Provider will write progress reports and assessments for the purpose of treatment planning, coordination of care, and authorization for payment of services including for local and state agencies which may be involved in my/my child's/incompetent person's care. ____(initials)

III. Confidentiality and Disclosure

I understand that most information disclosed to the Provider is protected by federal and state regulations governing confidentiality and cannot be disclosed to others without my consent. I understand that due to Nevada state regulations, there are legal exceptions when my consent is not necessary to disclose information to others, including:

In cases of past, present, or suspected child abuse or neglect a report must be made to Child Protective Services no later than 24 hours after the information is revealed. In cases of abuse or neglect of a person older than 60, or of a disabled person or legally incompetent person, a report must be made to local law enforcement agencies. In cases where a client is in imminent risk of harming themself or others, or when a person with mental illness needs hospitalization, confidentiality may be suspended for the protection of the client and/or others, and/or when treating a mental illness. In cases when a person appears to have been injured by a knife, firearm or burn, this information must be reported to local law enforcement or local fire department officials. _____(initials)

Confidentiality may also be suspended when a client's treatment is part of a legal claim or defense, or when required by federal or state laws; when information about a deceased person's mental health services is necessary for determining the validity of a will; when a person is court ordered for a psychological evaluation; and in situations where a client's case is investigated by the Board of Examiners as part of an investigation or hearing. ____(initials)

IV. Release of Information

I understand that I will need to sign a release of information consent form for records to be released to other parties including a spouse, other agency providing services, etc. HIPAA permits the covered entity, Odyssey Wellness, to communicate with other mental health providers regardless of if a patient and/or legal guardian has signed a release of information. Information obtained during the process including necessary assessments, treatment plans, progress notes, and/or other documentation may be released to insurance provider(s) to ensure authorization, continuity of care, etc. via this consent. ____(initials)

V. Supervision of Cases

I understand my case may be staffed by clinicians within the agency, or as under contract, who are not licensed who may provide treatment services, testing, or other services, review records and provide treatment planning. My provider will be _____ who will be working under the supervision of _____. ____(initials)

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VI. Video and Tape Recordings

I understand tape recording may occur during therapy sessions with the Provider for use in supervision and treatment planning. I can request the recording be stopped at any time. The recordings will be used solely for training purposes within the office and only shared between the provider and the supervisor. The recording will be stored in a secure location and only accessed by others with my written permission. The recording will be immediately erased once it has been reviewed for training or in no event later than 30 days from collection. ____(initials)

VII. Attendance Policy

I understand that therapy appointments are scheduled every 45 minutes. My appointment time is set aside for me and if I am late, I realize that my session will be shortened, or, after 15 minutes will be considered a "no-show" and the appointment will need to be rescheduled. Private pay clients will be billed for the cost of the full session. ____(initials)

I understand that if I, or my child/incompetent person, have excessive missed appointments as determined by the Provider, services may be terminated, and an appropriate referral will be made. If 3 consecutive appointments are missed there is no guarantee the same clinician or time slot will remain available, and it may be necessary to perform a new intake. If the initial appointment or testing appointment is missed it may take up to 2 months to reschedule. ____(initials)

VIII. Professional Therapeutic Relationship

I understand that the relationship with my assigned provider is a professional therapeutic relationship and acknowledge that I do not have any other type of relationship with the provider. I understand that gifts to/from the provider or bartering or trading services are not allowed. ____(initials)

IX. Potential Risks

I understand there are risks associated with receiving mental health services. I may learn things about myself, or my child/incompetent person, that I do not like. I understand that as I, or my child/incompetent person, experiences and confronts issues it may cause feelings of sadness, anxiousness, or other emotional pain. I understand that success depends on the quality of effort I, and/or my child/incompetent person, put into treatment and I realize I am responsible for lifestyle choices and changes that may occur. _____(initials)

X. Transfer of Case

I understand that Odyssey Wellness has direct responsibility for my treatment.
Should my provider not be available to provide services due to unforeseen circumstances including disassociation from the agency, illness, incapacitation, or death, I authorize to be reassigned to another provider, or, upon my written request and consent, for appropriate records to be provided to another provider or agency of my choosing. _____(initials)

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XI. Emergencies

I understand my provider is not available 24 hours a day, 7 days a week, and that there are other options to receiving emergent care. I understand that if I/my child/incompetent person am/is feeling suicidal, homicidal, or otherwise in need of immediate care I am to call 911 and/or report to the nearest hospital emergency room. I understand I can also access after-hours care by calling after-hours crisis lines as explained to me. The numbers are included below. _____(initials)

Emergency Phone Numbers:
- Call 9-1-1 or go to the closest emergency room
- Southern Nevada Adult Mental Health Services, Hotline: (702) 486-8020; Voice: 702-486-6400
- Spring Mountain Hospital, (702) 873-2400, 24/7 Services
- Seven Hills Behavioral Hospital, (702) 947-2650
- National Suicide Prevention Lifeline, (800) 273-8255
- Nevada Suicide Prevention Hotline, (877) 885-4673
- Mobile Crisis Response Team-MCRT, (702) 486-7856

XII. Records

I understand the laws and standards of the Provider's profession require that they keep treatment records. According to NRS 629.051, the Provider maintains client records for 5 years following termination of services, unless the client is a minor, in which case the records are maintained for 5 years past the age of majority (or until the client is 23 years of age). After 5 years the Provider may choose to dispose of my health records in a legally and ethically appropriate manner. I understand if I request copies of my health records the Provider may charge me a .50 cents per page fulfillment fee. ____(initials)

XIII. Freedom of Choice

The provisions of the contract shall not alter the right of recipients to the free choice of doctor, hospital, or other provider of care, unless such freedom of choice is lawfully restricted by the Department of Medicaid. The legal responsibility of providers to patients shall not be affected hereby. _____(initials)

XIV. Telehealth Services

To the extent permitted by Medicaid, governing bodies, and other insurers, services may be performed via electronic communication with video and sound. Should I choose to participate in telehealth services, a separate Telehealth consent form will be provided to me. _____(Initials)

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XV. Insurance Reimbursement

Insurance is verified, prior to the start of services, however, you (not your insurance company) are responsible for full payment of the fees if any change in insurance is not communicated to this office. Should there be any concerns about insurance coverage, you will be notified and any scheduled appointments will pause until the insurance matter is rectified. If the matter is not resolved, alternative arrangements will need to be made for payment, if services are to be continued. Sliding scale fees are available should there be a financial hardship, and such arrangements would need to be approved prior. _____(Initials)

XVI. CONSENT

I voluntarily agree to receive or allow (in the case of a minor/legal incompetent person who I have legal custody), mental health assessment, care, treatment, or services and authorize the Provider and/or Odyssey Wellness to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services at any time.

By signing this consent form, I acknowledge that I have both read and understood all the terms and information contained herein and have been provided ample opportunity to ask questions and seek clarification of anything unclear to me.

_____
Client Name

_____ _____
Signature Date

_____ _____
Legal Guardian Name if Different from Client Relationship

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CONSENT FOR CONFIDENTIAL COMMUNICATION THROUGH ELECTRONIC MEANS

Client Name: _____ Date of Birth: _____
(Last) (First) (MI) (Month/ Day/ Year)

Odyssey Wellness complies with HIPAA and other privacy or security laws and standards regarding the access, use, or disclosure of protected health information (PHI) or electronic protected health information (EPHI). Odyssey Wellness requires your consent to communicate your confidential information through electronic means (i.e. telephone, email, etc). Please check the appropriate boxes and initial next to your response.

Home Phone

☐ Yes (_____) ☐ No (_____) You may contact me at my home phone.
If yes, please list home phone number: _____
☐ Yes (_____) ☐ No (_____) You may leave voice messages at my home number.
☐ Yes (_____) ☐ No (_____) You may leave a message with members of my family.
☐ Yes (_____) ☐ No (_____) Restrictions : _____

Work Phone

☐ Yes (_____) ☐ No (_____) You may contact me at my work phone.
If yes, please list work phone number: _____
☐ Yes (_____) ☐ No (_____) You may leave voice messages at my work number.
☐ Yes (_____) ☐ No (_____) You may leave a message at my employment.
☐ Yes (_____) ☐ No (_____) Restrictions : _____

Cell Phone

☐ Yes (_____) ☐ No (_____) You may contact me at my cell phone.
If yes, please list cell phone number: _____
☐ Yes (_____) ☐ No (_____) You may leave voice messages at my cell number.
☐ Yes (_____) ☐ No (_____) You may text me at my cell number.
☐ Yes (_____) ☐ No (_____) Restrictions : _____

Email

☐ Yes (_____) ☐ No (_____) You may contact me at my email address.
If yes, please list email address: _____
☐ Yes (_____) ☐ No (_____) You may send unencrypted emails/documents.
☐ Yes (_____) ☐ No (_____) You may email the following information:
☐ Yes (_____) ☐ No (_____) General inquiries (i.e. appointments, requests, etc.)
☐ Yes (_____) ☐ No (_____) Reports, treatment plans, etc. related to treatment which includes specific details about my mental health and/ or treatment.
☐ Yes (_____) ☐ No (_____) Restrictions : _____

I authorize Odyssey Wellness to communicate confidential information to me by the means indicated above and understand that Odyssey Wellness is not responsible for any re-disclosure based upon the consent provided.

Client Signature: _____ Date: _____
Legal Guardian: _____ Date: _____
Guardian Signature: _____ Date: _____

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AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION (ROI)

Client Name: _____ **Date of Birth**: _____
(Last) (First) (MI) (Month / Day / Year)

I, _____, authorize for my information to be disclosed to:
(Patient, Parent, or Legal Guardian First and Last Name)

Agency: _____ Name: _____
Address: _____ Phone: _____
_____ Fax: _____

Form(s) of disclosure authorized:
☐ (_____) Verbal
☐ (_____) Written ☐ (_____)Written (email)

The following may be disclosed:
☐ (_____) Assessments/Diagnosis
☐ (_____) Psychiatric/Psychological Evaluations
☐ (_____) Treatment plans/discharge summary ***The***

following information may be disclosed by the above:

☐ (_____) All substance health information related to my ☐ (_____) Progress Notes medical,

mental, physical condition and treatment except: ☐ (_____) Educational Records

☐ (_____) Other:
_____

☐ (_____) All HIV information related to my medical, _____ mental, physical condition and treatment except: _____
_____ _____

Information is to be provided promptly to the following:

Agency: _____ Name: _____
Address: _____ Phone: _____
_____ Fax: _____

Reason for release is (check all that apply):
☐ (_____) At my request
☐ (_____) To facilitate diagnosis, evaluation, treatment planning, and treatment
☐ (_____) To assist in the application process for benefits for which client may be entitled
☐ (_____) Other (specify):

This authorization ends: ☐ (_____) on date: ☐ (_____) when the following occurs:

My Rights (read before signing):

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). However, that I do have to sign authorization to take part in a research study or to receive health care when the purpose is to create for or release health information to a third party. I understand I may revoke this authorization at any time provided it is in writing although it would not affect any actions already taken by the above based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. By signing this authorization, I am waiving my rights, if any, to confidentiality as indicated above. Although bound by the same privacy laws, I understand once Odyssey Wellness discloses information the receiving party may re-disclose which Odyssey Wellness has no control. **A photocopy of this consent shall be considered as valid as the original and will be electronically stored.**

Client/Legal Guardian Signature: _____ Date/Time: _____/_____

Printed name (if legal guardian):_____ Relationship:_____

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NOTICE OF PRIVACY PRACTICE
Health Insurance Portability and Accountability Act (HIPPA)

This notice described how medical information about you may be used/ disclosed and how you can get access to this information.

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services if referred to as "protected health information" (PHI) and for the purposes of this notice includes electronic PHI (ePHI). This notice of privacy practices describes how we may use and disclose your PHI in accordance with applicable laws and ethical standards. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this notice of privacy practices. We reserve the right to change the terms of our notice of privacy practices at any time. Any new notice of privacy practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised notice of privacy practices by posting a copy in our lobby, sending a copy to you in the mail at your request or by providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

FOR TREATMENT. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members associated with Odyssey Wellness. We may disclose PHI to any other consultant or third party provider only with your authorization.

FOR PAYMENT. We may use and disclose PHI so that we can receive payment for the treatment services provided to you.
Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

FOR HEALTH CARE OPERATIONS. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g. billing) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teach purposes, PHI will be disclosed only with your authorization.

AS REQUIRED BY LAW. Under the law, we must disclose your PHI to you upon your request. In additional, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the privacy (and/or security) rule.

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WITHOUT AUTHORIZATION. The following is a list of categories of uses and disclosures permitted by HIPAA without an authorization. Applicable laws permit us to disclose information about you without your authorization only in a limited number of situations.

- **Child abuse or neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse and/or neglect.
- **Judicial and administrative proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
- **Deceased patients.** We may disclose PHI regarding deceased patients as mandated by law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.
- **Medical emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family involved in care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, and, for the purpose of identifying a suspect, connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized government functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the department of state for medial suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Research.** PHI may only be disclosed after a special approval process.

VERBAL PERMISSION. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

WITH AUTHORIZATION. Uses and disclosure not specifically permitted by applicable law will be made only with your written authorization, which you may revoke at any time with written notice.

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YOUR RIGHTS REGARDING YOUR PHI

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 at: **Odyssey Wellness, ATTN: Dr. Sarah Ahmad, 3067 E. Warm Springs Road, Suite 100 Las Vegas, NV 89120. Office: 702-650-6508. Fax: 702-920-8865.**

- **Right of access to inspect and copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained In a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies ($.65 per page).
- **Right to amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the privacy officer if you have any questions.
- **Right to an accounting of disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than once accounting in any 12-month period.
- **Right to request restrictions.** You have the right to request a restriction of limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to request confidential communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- Right to a copy of this notice. You have the right to a copy of this notice and any subsequent changes.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our privacy officer at :
Odyssey Wellness, ATTN: Dr. Sarah Ahmad, 3067 E Warm Springs Road Suite 100 Las Vegas, NV 89120. Office: 702-650- 6508. Fax: 702-920- 8865, or with the Secretary of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201, or by calling (202) 619-0257. The entire federal laws regarding HIPAA can be found at: http://www.hhs.gov/ocr/privacy/index.html.

WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT

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ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Odyssey Wellness's Notice of Privacy Practices.

I acknowledge that I understand how Odyssey Wellness may access, use, and disclose my protected health information (PHI). I understand my rights in regards to my PHI and the legal duties of Odyssey Wellness to protect my PHI. I acknowledge that any questions I have regarding my protected health information have been addressed to my satisfaction.

I understand that I may request another copy of the Notice of Privacy Practices upon request or by visiting an Odyssey Wellness office and viewing a copy of the Notice of Privacy Practices in the lobby.

_____ _____

Client Signature Date

_____ _____

Legal Guardian Signature (if minor or legally incompetent person) Date

_____

Relationship to Client

☐ Client or ☐ Legal guardian refuses to sign acknowledgment.

Reason:

_____

_____

_____ _____

Employee Signature (if Client/legal guardian refuses to sign) Date