Breakthrough
Mental Healthcare LLC

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PMHNP-BC CONSENT FOR TREATMENT

In order to consent to mental health treatment, you need to know the following information. This Consent is for patients or the parent/guardian/managing conservator of minor child patients of Breakthrough Mental Healthcare LLC ("Breakthrough").

Breakthrough is currently staffed by Tonia M. Ajamu ("Ajamu"), MSN, APRN, PMHNP-BC as the sole mental healthcare provider. Ajamu is a Psychiatric and Mental Health Nurse Practitioner – Board Certified (PMHNP-BC).

An PMHNP-BC is not a doctor. An PMHNP-BC is an advanced practice registered nurse (APRN) who has received advanced education and training in providing a wide range of psychiatric and mental healthcare services to patients and families in a variety of settings. PMHNP-BC's diagnose, conduct therapy, and prescribe medications for patients who have psychiatric disorders, medical organic brain disorders, or substance abuse problems. They are licensed to provide emergency psychiatric services, psychosocial and physical assessment of their patients, treatment plans, and manage patient care.

Informed Consent. I understand I have the right to make an informed decision about treatment. Ajamu has explained the treatment plan to me.

Patient's Rights. Patients have the right to request a consultation with the Clinic Administrator or a Supervisor. I understand Ajamu will usually consult with a doctor, as required by law, regarding the best treatment plan.

Voluntary, Informed Consent to Treatment. My signature below indicates voluntary consent for the treatment plan for myself or the minor child. If for a minor child, I hereby attest I am the legal guardian of the minor child and have the right to consent to treatment for this child. This consent applies to all providers at Breakthrough who may provide services and permits the sharing of information amongst Breakthrough staff.

Duration of Consent. I understand that consent expires after 15 months and I have the right to withdraw this consent in writing at any time. I understand this consent is for treatment and does not include participation in research.

Fees and Insurance. The fee for an initial diagnosis and evaluation is $300.00, and a follow up visits will be $150.00 for private pay rate. A patient who does not have insurance coverage will be charged this amount. Some insurance companies may partially cover these costs. In the event your insurance carrier declines benefits, you acknowledge and agree that you are fully responsible for the charges and expect them to be applied to your account. If you have coverage you can assign the benefit and pay only your copay or coinsurance at the time of each visit. If your deductible has not been met, you are responsible for payment at the time of visit. Law does not allow for the waiver of deductibles or copayment.

If you choose to use your insurance, you understand that certain information about your case will be shared with your insurance company and or an intermediary for purposes of filing the claim.

By consenting to treatment, you acknowledge that you are responsible for the cost of services provided to you or your minor child and agree to pay them when billed or at time of service. If services are not paid you agree to pay a service charge and or any finance charge that may apply. After 90 days your account may be assigned to an outside collection

agency in which case you will be responsible for paying attorney and or collection fees and expenses. there will be a charge of $25.00 after 90 days for collection fees.

A 24-business hour notice is required for cancellation of an appointment. The fee for a missed initial appointment without the 24-business hour notification is $150.00 and for a follow up appointment is $75.00. Insurance does not cover missed appointments and therefore you are solely responsible for the payment of the fee.

Medication Refill/Prior Authorization Policy. There is a $25.00 charge for each prior authorization that our office is required to obtain and for any prescription you need filled outside of your office time. This fee is required to be paid before the service is rendered. Medication request are only addressed during business hours.

Returned Checks. There will be a fee of $50 for returned checks.

Medical Records. If you need to request your medical records, you must provide a signed notification and give a two-week notice. There will be a charge of $25.00.

Forms, Letter Request. In the event you need us to provide any forms or letters on your behalf there will be a fee ranging between $100.00 and $300.00 based on time and complexity. You will be responsible to pay at the time of request.

Legal Actions/Court Appearance. If legal action occurs in which your provider is requested or subpoenaed to provide testimony you will be responsible for the following even if the subpoena is sent from the opposing side of the case:

A) Travel Expenses
B) Hourly or per diem fees based on our current fees from the time the provider leaves the office until she returns.
C) A minimum of fifty percent of the cost will be required prior to the court appearance.
D) Record copying will be $25.00
E) Provider Fee is $300.00 per hour (minimum 6 hours will be billed).

Emergency Care. In case of an emergency, I understand Breakthrough reserves the right to administer medical treatment on the premises or to contact and advise emergency personnel on the premises or at an emergency room regarding my needs at that time.

Danger. In the event your provider in her clinical judgement believes you to be a danger to yourself or others, by signing this consent, you authorize her to contact your listed emergency contact or someone else to help provide assistance through this crisis situation.

Indemnification. I will indemnify and hold harmless from any expense or claim of any nature any person or entity that provides or causes to be provided examination, treatment, or hospital care under this authorization (except to the extent such person or entity is negligent therein) and conditionally agree to make or cause to be made, by assignment of third-party benefits or otherwise, full and complete payment for such examination, treatment, or hospital care.

Limits to Confidentiality. The information I give in treatment is generally confidential and will only be released outside of Breakthrough with my written permission (or with the permission of a parent or guardian of a minor). However, I acknowledge these limits to confidentiality under Texas and federal statutes: (i) Ajamu may use information within Breakthrough and with its business associates for treatment, payment, and other healthcare operations. (ii) Ajamu will consult with physicians in order to provide a high quality of care, to answer certain subpoenas or court orders, to report threats of homicide or suicide, to report the suspicion of child abuse or child neglect, and may report elder abuse or abuse of a handicapped person or crime which may occur in the future. (iii) Ajamu may report physical assaults or crimes which occur on the site of appointment. (iv) Ajamu may report prenatal exposure to controlled substances.

Limited Disclosures. All disclosures will be made to the appropriate parties as directed by law, such as authorities, parents of minors, or intended victims of violence. When Ajamu must release information without your consent, the information revealed will be limited to what is necessary to protect you or to protect others, or the limited information necessary for collection of a past due bill, or the information ordered to be released to the court. When information is released with your consent, we will release the information you request us to disclose.

Termination of Services. I understand and agree that I am entering into a therapeutic relationship with my provider. The success of the treatment is contingent upon active participation and constant attendance. More than three no shows will result in termination of services. Your file will be closed after sixty days of zero communication and no appointment.

Acknowledgement. I hereby acknowledge that I received an explanation of this consent, the limits of confidentiality, the proposed treatment plan, and the payment plan. I received a copy of the information in this form, Breakthrough's HIPAA Privacy Notice.

I have read the above, and hereby consent to the services of the PMHNP-BC for my (or the minor child's) mental healthcare needs.

I understand that at any time I can refuse to see the PMHNP-BC and request to see a physician.

Print Name of Patient: _____
Patient's Signature:_____

Patient's Date of Birth: ____/____/_____

If Patient is a Minor Child, please complete and sign below.

Print Name of Minor Child Patient: _____ Minor Child's Date of Birth: ____/____/_____

Print Name of Parent/Guardian/Managing Conservator: _____

Signature: _____ Date: ____/____/_____
Parent/Guardian/Managing Conservator