Blue Umbrella Psychiatry
6100 Griffin Rd. 2nd Floor
Davie, FL - 33314-4416

*BUP's New Consent, Office Policies, and HIPAA 2026__

I hereby voluntarily seek and consent to participate in psychiatric evaluation, treatment, and/or therapy services with Eric Robbins, MD, a board-certified Adult, Child, and Adolescent Psychiatrist licensed in Florida, and with other licensed practitioners within Eric Robbins MD LLC DBA Blue Umbrella Psychiatry.

If the patient is a minor, I give my consent as the parent or legal guardian for my child to receive psychiatric and/or therapy services from Dr. Robbins and the practice's authorized clinicians. I understand that no guarantees have been made regarding the results of treatment, evaluation, or therapy, and that outcomes may vary. I also understand that I may request information regarding the credentials, education, and experience of Dr. Robbins or any other clinician providing care.

Confidentiality and Therapy Notes

I understand that mental health services are provided with a high degree of confidentiality. Federal and Florida laws, regulations, and professional ethics require clinicians to maintain the confidentiality of information disclosed during treatment or therapy sessions.

Psychotherapy/Therapy Notes: Therapy notes, which may include private impressions, observations, or reflections made by a therapist during a session, are maintained separately from the medical record. These notes are protected and cannot be released without my explicit, separate authorization, except as required by law.

Medical/Psychiatric Records: Records related to psychiatric treatment, including diagnoses, medications, and treatment plans, may be accessed by authorized personnel for treatment, supervision, and care coordination.

Exceptions to Confidentiality

I acknowledge that my information may be disclosed without my consent only as required or permitted by law, including:

Insurance or Billing: Agents of my insurance company may receive information regarding the type, dates, cost, and providers of services rendered.

Safety Concerns: Situations involving acute risk of harm to self or others.

Abuse or Neglect: Suspected child abuse/neglect or elder abuse/neglect.

Legal Requirements: Subpoenas, court orders, or other legal mandates.

Collaborative Care and Supervision

I understand that clinicians within Blue Umbrella Psychiatry may discuss my care with other authorized clinicians for the purposes of treatment, supervision, or care coordination. These discussions are strictly professional and confidential. Only clinicians directly involved in my care or supervising my care have access to my electronic health records.

By signing this form, I acknowledge that I have read and understood the information above, that my questions have been answered to my satisfaction, and that I consent to evaluation, treatment, and therapy services under the terms described.

Please go through our policies and give consent to start treatment with us. Please consider this a legal-binding document and go through these policies carefully. If you have any questions, you may contact our office at (954) 341-5215.

1. OFFICE POLICIES & FINANCIAL AGREEMENT

PAYMENT:

The policy of Blue Umbrella Psychiatry LLC is to collect all payments at the time services are rendered. We will provide you with an estimate of benefits if you have insurance. I acknowledge that I am responsible for any applicable copayments, coinsurance or deductibles associated with my visit. I am aware that the estimation of benefits provided is not a guarantee, and I commit to paying the mentioned costs. I understand that it is illegal for the provider to waive these fees and I accept full responsibility for payment. I understand that it is my responsibility to report any insurance changes to the office. I recognize that failure to do so may result in insufficient coverage and any appointments would become my financial responsibility. We will bill all insurance companies we are contracted with us. The remaining balance will be billed to the patient. For your convenience we accept most major credit cards and all debit cards. We require that a credit card be placed on file so that charges can be made as services are rendered. *

☐ I understand and consent

Office Policies

TREATMENT ATTENDANCE AND CANCELLATION POLICY If you become a regular patient at the practice, you will be required to have an appointment scheduled with your clinician in our books. You will need to

make sure follow-ups are being made at the recommended time stated by your clinician. If you have not been seen in our office for over four months without that being part of the written plan, your case will be closed in our office. Should you need any further services after your chart has been deactivated, you will need to go through our regular intake process again. To protect the time of Dr. Robbins and his associates, we ask that you provide at least 24 hours' notice for cancellations or rescheduling so that we may offer the appointment slot to another patient. If you cancel with less than 24 hours' notice, you will be charged a $75 fee to the card on file or be billed. For any TRD or Breakthrough Center treatment (including Spravato, TMS, and Ketamine), the late cancellation fee is $100. If you are more than 15 minutes late to your appointment of 30 minutes or longer, it will be considered a late cancellation and the applicable fee will apply. If you are over 5 minutes late to your appointment of less than 30 minutes, it will be considered a late cancellation and the fee will automatically apply ($75 for standard visits, $100 for TRD/Breakthrough Center treatments). If you are a no show for your appointment, meaning you miss the appointment completely with no call beforehand, you will be responsible for the full self-pay cost of the appointment. For psychiatric

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evaluations, the fee is $300 for the first appointment and $150 for follow ups. The fee would also be $150 for therapy appointments. A no show fee for TRD or Breakthrough treatment would be $100. The best way to cancel or reschedule is by calling or texting our office. You will receive appointment reminders in advance to help you keep track of your scheduled visit. If you are regularly missing or late to appointments, you may be discharged from the clinic. We do understand that life is complex, and things arise. We ask you to be transparent with us if you are experiencing challenges with treatment attendance, so we can work together to figure out a solution. We appreciate your cooperation and understanding. *

IN-PERSON TREATMENT: Blue Umbrella Psychiatry is primarily an in-person office, and almost all appointments are presumed to be in-person. Evaluations and first appointment are required to be in-person. If you are interested in telehealth, you must get clearance from our clinical team. Patients prescribed a controlled substance are required to have an in-person appointment once every three months. *

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TELEHEALTH CONSENT I acknowledge that if my provider and I mutually agree to conduct a telehealth session, I understand that this session will be held via secure, HIPAA-compliant technology platforms. Blue Umbrella Psychiatry uses these platforms to ensure the confidentiality and privacy of my health information. I consent to participate in telehealth services and acknowledge that while Blue Umbrella Psychiatry strives to provide a secure environment, interruptions or technical issues may occasionally occur. I understand that Blue Umbrella Psychiatry is not responsible for any breaches of confidentiality, interruptions, or technical issues that may arise during a telehealth session. I also understand that I have the right to refuse telehealth services and request in-person visits instead, as appropriate. *

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USE OF ARTIFICIAL INTELLIGENCE Blue Umbrella Psychiatry may use secure transcription technology, including speech-to-text or AI-assisted tools, to help providers create documentation more efficiently. These tools are used only for transcription purposes and do not replace clinical judgment or decision-making. All notes are reviewed and finalized by your provider, and your health information remains protected under HIPAA and all applicable privacy laws. I understand that if I am uncomfortable with the use of this technology, I can speak to the clinician and request it not be used. *

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MEDICATION: Refills should be requested directly to the patient portal rather than the pharmacy. Please give us at least 5 days' notice for refill requests so that you don't run out of medications on a weekend or holiday. Refills for medication are meant to occur during your visit with the doctor. The doctor puts a lot of thought into prescribing medications each and every time and this is the reason it should be done at the time of your appointment. Please consider that certain medications will require appointments prior to being refilled and it is your responsibility to ensure you schedule a follow-up appointment with enough time to receive your medication. *

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MEDICAL RECORDS/FORMS/LETTERS: With a signed release, we provide treatment and summary letter, when requested by you or a third party. Short term disability and FMLA forms will only be completed by our clinicians once you are an established patient in our care with a minimum of either six visits by the clinician or six months duration, whichever comes first. There is a standard $50 fee for any of these forms. *

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CONSENT TO TREATMENT FOR MINORS: Consent for treatment with a child under the age of 18 years old must be provided by both parents. The scheduling parent must provide us with contact information for other parent for us to obtain consent. Exception is sole custody in which case documentation must be provided and placed into file. *

☐ I understand and consent

PATIENT PORTAL: I understand that I must sign up for the patient portal provided to me. I also understand that this is the primary way to contact my provider directly. Any request I make to my provider for clinical questions or medication requests through this portal will be answered within 48 hours. *

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PATIENT DISCHARGE: Our office maintains an environment of mutual respect and kindness. I recognize that if I demonstrate disrespectful, rude, belligerent, or aggressive behavior toward any clinician or staff member, I may be discharged from the practice and unable to continue treatment. I recognize that I may also be discharged for dishonesty or deceit toward clinicians, non-adherence to treatment recommendations, or regularly missing or failing to attend scheduled appointments. Discharge may also become necessary if my clinician feels a higher level of care is required. *

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COLLABORATIVE CARE, FAMILY TREATMENT, AND INTERNAL CASE CONSULATION: Eric Robbins MD LLC DBA Blue Umbrella Psychiatry operates as a collaborative behavioral health practice, where psychiatrists, therapists, and other authorized clinicians work together to provide coordinated, high-quality mental health care. Providers may consult with one another and review patient records internally when clinically necessary for treatment, care coordination, supervision, or healthcare operations, as permitted under HIPAA and Florida law. When multiple members of the same family receive services within the practice (e.g., a parent receiving psychiatry while a child receives therapy), each individual is considered a separate patient. Providers may coordinate care internally for safety, treatment planning, and continuity of care, but confidential information shared by one family member will not automatically be disclosed to another. Clinicians exercise professional judgment regarding what information, if any, is appropriate to share to support treatment and safety.	☐ I understand and consent

STUDENT AND TRAINEE PARTICIPATION Blue Umbrella Psychiatry partners with Nova Southeastern University (NSU) and other accredited universities to provide clinical training for medical students, psychiatric nurse practitioner (PMHNP) students completing their preceptorships, and counseling interns pursuing their master's degrees. Students and interns may occasionally observe or participate in your appointment under the supervision of our licensed providers. Your participation is completely voluntary, and you may verbally let us know at any time if you prefer that a student or trainee not be present. *

☐ I understand

2. HIPPA NOTICE OF PRIVACY PRACTICES

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Blue Umbrella HIPPA Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have The Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

NOTICE OF PRIVACY PRACTICES

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for the military personnel and veterans, for nation security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for protective correctional institutions and other law enforcement custodial situations and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in a request to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

We may share you medical information if it is necessary to help law enforcement officials capture a person who has been admitted to being a part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose your medical information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose your medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings, inspections, licensure or disciplinary actions, authorized activities dealing with research monitoring or audits, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose your health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited concerning identification and location at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing by sending a letter to our Office. If you request copies, we will charge you $.25 for each page, and postage if you want the copies mailed to you.

2. Receive a list of all the times we or our business associates shared by your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

3. Request that we place additional restrictions on our disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing.

5. Request that we change your medical information. We may deny your request if we did not create the information you wanted changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

We follow HIPAA guidelines for your protection and you have the right to your medical information. I have read and understand the HIPAA policy above. *

☐ I have read and understand.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our staff members in person or by phone at our main phone number.

☐ I understand

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Dr. Eric Robbins MD LLC, and will comply with them in all respects. I acknowledge that I have received the HIPPA policy. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Name of Patient: * ______________________

Please submit your digital signature below.

Name of Guardian (if applicable): ______________________

Today's date: * ______________________