

Innovative Treatment Centers, LLC Notice of Practice Policy & Privacy

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.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

The Health Insurance Portability and Accountability Act (HIPAA; Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to maintain these records of your health care and to maintain the confidentiality of these records.

The Act also allows us to use the information for treatment payment and certain health operations unless otherwise prohibited by law and without your authorization.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. *For example:*

Treatment: We may disclose your protected health information to you and our staff or other healthcare providers in order to get you the care you need. This includes information that you may go to the pharmacy to get a prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.

Payment: We may send information to you or your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.

Health Operations: We are allowed to use or disclose your protected health information to train new healthcare workers, evaluate the health care delivered, improve our business development, or for other internal needs. We must disclose information as the law requires, such as public health organizations, health care oversight activities, certain lawsuits, and law enforcement. Certain ways that your protected health information could be used or disclosed require authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses of disclosure not described in this NPP.

Your Authorization: We cannot disclose your protected health information to your employer, primary care physician, school, and/or third party without your authorization unless required by law. Medical release authorizations will be valid for one year from the date signed or if you indicate a specific termination date on the release authorization. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation when we receive the written, signed revocation. You have several rights concerning your protected health information. If you wish to use one of these rights, please inform our office so that we can give you the correct form to document your request.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location your general condition, or death. If you are present, then before the use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health 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 disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials the health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Electronic Signature (E-Signature): This Electronic Signature (E-Signature) Disclosure and Consent sets forth the terms and conditions governing my consent to sign documents electronically through, and my use of, Innovative Treatment Centers, LLC and the current electronic medical records system. I may decline to electronically sign any document by verbally informing the staff. I acknowledge that declining to electronically sign or complete any document will require me to complete a paper copy of any documents they may need on file.

Effect of my Consent: I understand that electronically signing and submitting any document(s) to Innovative Treatment Centers, LLC, legally binds me in the same manner as if I had signed in a non-electronic form, and the electronically stored copy of my signature, any written instruction or authorization and any other document provided to me by the practice, is considered to be the true, accurate and complete record, legally enforceable in any proceeding to the same extent as if such documents were originally generated and maintained in printed form. I agree not to contest the admissibility or enforceability of the electronically stored copy of this Consent and any other documents. By using the System to electronically sign and submit any document, I agree to the terms and conditions of this Consent.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, text messages, emails, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow access or provide a copy within 30 days of our request. We may provide the copy to you or your designee in an electronic format acceptable to you or a hard copy.

We may charge you our cost of making and providing the copy. If your request is denied, you may request a review of this denial by a licensed healthcare provider.

Restrictions: You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket and if the restriction is not otherwise forbidden by law. For example, we must submit information to federal health plans and managed care organizations even if you requested a restriction.

We must have your restriction documented before initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information to the health plan.

Alternative Communication: You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication to comply. If the alternative means of communication incurs additional cost, that cost will be passed on to you.

Your medical records are legal documents that provide crucial information regarding your care.

Amendment: You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.

You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information.

You have the right to receive a copy of this notice, either electronic or paper or both.

You have the right to opt out of fundraising communications.

You have a right to receive a copy of your laboratory test results directly from the laboratory within 30 days of your request or completion of the report, whichever is longer.

We will provide results for any tests performed in-house. Patients must request results directly from other laboratories (reference or hospital labs) that performed the test.

QUESTIONS AND COMPLAINTS

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective May 18, 2022.

If you want more information about our privacy practices or have questions or concerns or disagree with a decision we made about access to your health information or in response to a

request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you have the right to file a complaint with us or with the Office of Civil Rights. We will not discriminate or retaliate in any way for this action.

We support your right to the privacy of your health information.

To file a complaint, please contact the applicable party:

Privacy Officer: Innovative Treatment Centers, LLC

Phone number: 443-430-2998

Fax number: 443-431- 8978

To contact the Office for Civil Rights, please email civilrights@aog.state.md.us, or call 410-576-6300 or 888-743-0023 toll-free.

CONTACT INFORMATION

Our office number is 443-430-2998. We respond to calls and text messages.

For non-urgent matters, please allow 48 business hours for a response. Messages left late in the day, on weekends or holidays, may not be returned until the next 1-2 business day.

If you or someone close to you is in immediate danger, please call 9-1-1 or proceed to the nearest emergency room.

By signing below, you certify that you have read and understand the terms in the Treatment Consent Form. You indicate that you understand and agree to abide by the terms stated above during our therapeutic relationship.

CONFIDENTIALITY

The security of sensitive information is of utmost importance to us, and we are bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent. As described above, basic information about your treatment may be disclosed to your insurance company for prior authorizations.

There are exceptions to this confidentiality, where disclosure is mandatory. These include the following: A threat of harm to your safety and /or others which may require immediate hospitalization Legal hearings to determine your emotional or cognitive condition. Situations where a dementing illness, epilepsy, or other cognitive dysfunction prevents you from operating a motor vehicle in a safe manner. We will be required to report to DMV. Situations where there is suspicion or evidence of child or elderly abuse. These situations rarely occur in an outpatient setting. If they arise, we will do our best to discuss the situation with you before taking action. In some circumstances, we may find it helpful to consult with other professionals specialized in such situations (without disclosing your identity to them). Cookies are files with a small amount of data, which may include an anonymous unique identifier. Cookies are sent to your browser

from a website and stored on your computer's hard drive. We use "cookies" to collect information. You can instruct your browser to refuse all cookies or to indicate when a cookie is being sent. However, if you do not accept cookies, you may be unable to use some portions of our Service.

CRISP NOTICE OF PRIVACY PRACTICES

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions.

You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will remain available to providers.

CRISP Notice of Privacy Practices Acknowledgement Page: We participate in the CRISP health information exchange (HIE) to share your medical records with other healthcare providers and for other limited reasons. You have the right to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record-sharing policies at www.crisphealth.org.

DESCRIPTION OF TREATMENT SERVICES AND PROCESSES

MEDICATION

Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone. Medication may offer much-needed relief when a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or adequately care for your basic needs. If it is agreed that medications are indicated, we will discuss all available medication options to treat your current condition with you. We will present information in a language that you can understand. You will learn how the medication works, its dosage and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal effects you may experience if you stop taking the medication abruptly. By the end of the discussion, you will have all the information you need to decide which medication is proper. You may already receive psychotherapy from another therapist and are referred to me for medication management. In this case, we will make a solid effort to coordinate care with your therapist (with your consent). We believe communication between mental health professionals is critical to providing adequate care. Not everyone is a good candidate for medication therapy.

Such therapy requires strict dosage and frequency adherence, close follow-up, and sometimes regular urine and blood tests. Your adherence to medication treatment will be considered when starting such therapy. Overall, we are strong proponents of the bio-psycho-social medical treatment model. Treatment that considers your biological status, genetics, your psychological development, and social issues together will yield the best chance for success in achieving your goals.

PSYCHOTHERAPY

We will conduct a thorough review of your current complaints and your background. We will offer my preliminary impressions by the end of the initial visit and discuss your treatment options. Sometimes, psychotherapy alone will suffice. However, a combination of psychotherapy and medication management is often optimal. One of the most essential curative aspects of a therapeutic relationship is the goodness of fit between therapist and patient. The initial visit is also your opportunity to determine if we are the right providers for you. If you feel that we are not well matched to your needs, we would be happy to provide you with referrals to other mental health professionals. Psychotherapy, or talk therapy, is a powerful treatment for many mental complaints. It offers the benefits of improved interpersonal relationships, stress reduction, and a deeper insight into one's life, values, goals, and development. It requires a lot of motivation, discipline, and work from both parties for a therapeutic relationship to be effective. Patients will have varying success depending on their complaints' severity, capacity for introspection, and motivation to apply what is learned outside of sessions. Patients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings, and sensations such as guilt, anxiety, anger, or sadness, especially in its initial phases. It is not uncommon for these feelings to impact your current relationships. If this occurs, addressing these issues in the session is vital. Usually, these unpleasant sensations are short-lived.

At your initial visit, we will decide together on the structure of your care. If medications are prescribed or changed, we prefer to conduct a follow-up visit in one to two weeks. This is necessary to ensure proper administration and minimize any side effects you may experience. If your symptoms improve, follow-up visits can be spaced out monthly. For some patients on maintenance therapy, follow-up visits can be held at three-month intervals. If you are to undertake psychotherapy, weekly sessions will provide the best results. We may discuss an alternate treatment structure depending on your circumstances.

MEDICAL RECORDS

We are required by law to keep complete medical records. Most medical records will be electronically encrypted. Any written records will be stored in a secure file. You are entitled to review your medical records, which will be provided to you for a fee.

TERMINATION OF CONTRACT

Innovative Treatment Centers LLC is committed to fostering an inclusive, welcoming, and friendly environment for everyone, regardless of race, gender identity, or sexual orientation. If efforts to rehabilitate the relationship are not appropriate or unsuccessful, Innovative Treatment Centers reserves the right to end the patient-provider relationship under the following circumstances.

Treatment nonadherence: The patient does not follow the treatment plan or the terms of a controlled substance contract or discontinues medication or therapy regimens prior to completion.

Follow-up noncompliance: The patient repeatedly cancels follow-up visits or fails to keep scheduled appointments with providers or consultants. Any patients who have two late cancellations or no-call, no-shows in a row within 30 days will result in being discharged from services, and referrals to outside providers being provided. If a patient would like to return for services they may do so after 30 days by calling the office, understanding that the former provider may not have availability.

Office policy nonadherence: The patient fails to observe office policies, such as those implemented for prescription refills or appointment cancellations or refuses to adhere to mandated infection-control precautions.

Verbal abuse or violence: The patient, a family member, or a third-party caregiver is rude, uses disparaging or demeaning language, or sexually harasses office personnel or other patients, visitors, or vendors; exhibits violent or irrational behavior; makes threats of physical harm; or uses anger to jeopardize the safety and well-being of anyone present in the office.

Display of firearms or weapons: The patient, a family member, or a third-party caregiver wields a firearm or weapon on the premises.

Inappropriate or criminal conduct: The patient exhibits inappropriate sexual behavior toward providers or staff or participates in drug diversion, theft, or other criminal conduct involving the practice.

Nonpayment: The patient owes a backlog of bills and has declined to work with the office to establish a payment plan or has discontinued making payments that had been agreed on previously.

If termination of patient-provider relationship occurs under these circumstances, Innovative Treatment Centers will send a letter via email and/or to the address included on file via certified

mail. We will continue to provide immediate care for 30 days or until you have secure transfer of care. At the provider's discretion, we may refill your prescription(s) and encourage you to follow up with another provider for treatment.

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

- 1.) I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format. I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
- 2.) I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Maryland at the time of this service.
- 3.) I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.
- 4.) I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to: It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures. Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network. Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
- 5.) I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.
- 6.) I understand that medical information, including medical records, is governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).
- 7.) I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

8.) I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

9.) I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services.

10.) I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

11.) I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider. I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

12.) I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

13.) I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

14.) I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit. I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature, with the opportunity to have questions answered to my satisfaction.

FINANCIAL FEES AND OBLIGATIONS

Prior to consenting to treatment, Innovative Treatment Centers, LLC. ("The Practice") will discuss the estimated cost of payment and payment options with the patient. The practice billing

policy states that if a patient does not have insurance coverage, the patient may be billed by Innovative Treatment Centers, LLC. For patients with insurance, services will be billed by the practice through the patient's insurance company. It is the patient's responsibility to know their insurance benefits and whether or not the services they are to receive are covered benefits and to notify the office staff immediately when coverage changes. The patient will be responsible for any deductible, co-pay, co-insurance, financial responsibility, and/or balance due that practice is unable to collect from the insurance carrier for whatever reason. If there is a patient responsibility due for visits, the deductible, co-pay, co-insurance, financial responsibility, and/or balance due are collected at the time of service.

Medicaid clients are exempt from any financial obligations to Innovative Treatment Centers, LLC.

Medicaid recipients will not be billed for any missed or late cancellation appointments.

FEES AND PAYMENTS FOR PRIVATELY INSURED CLIENTS/SELF-PAY CLIENTS

Services may be covered in full or part by your health insurance.

Privately insured/self-pay patients are responsible for paying all fees before initial and subsequent patient appointments (e.g., psychotherapy, medication management, bariatric assessments, ADHD testing, etc.). Patients are required to satisfy each patient *before the scheduled appointment*. Failure to pay all fees and/or co-payments will result in the practice canceling subsequent appointments until all fees and/or co-payments are satisfied. All patients are responsible for updating the office staff if there are any changes to their address, phone number, and insurance information before the scheduled appointment. The practice reserves the right to verify the patient's insurance information and will notify the patient of fees and/or co-payments due *before the scheduled appointment as a courtesy*. The practice also reserves the right to send the client an invoice for outstanding fees and/or co-payments to the patient's provided mailing and/or email address.

Please check your coverage carefully before making your appointment.

Out-of-pocket rates are as follows:

1.) For an initial psychiatric evaluation our fees are \$285.00. Fee for initial psychiatric spinal cord stimulator or evaluation for bariatric surgery will be \$200.00. Self pay fees for ADHD testing is \$250.00. For psychotherapy sessions (including pain reprocessing therapy and 60 minutes of EMDR), the fee is \$180.00

- 2.) The fee for a medication management visit is \$150.00 unless psychotherapy or other services are provided, and fees will be determined according to the services rendered.
- 3.) Other miscellaneous services, such as filling forms, telephone correspondence, prior authorizations, and court hearings, will require a fee depending on minutes spent to complete task intervals. Fees may change at the medical director and provider's discretion. Providers specializing in services may offer different fees and may not accept your insurance. If my fees are to increase, we will provide you with thirty days' notice to alert you to the change.
- 4.) Letters, forms, record reviews, and interactions with outside agencies requiring significant attention outside of scheduled appointment times will be filled out at the provider's discretion. Any form that requires a considerable amount of time will not be completed on the same day and will be subject to a fee of \$75 per hour. Please allow 48 to 72 business hours for completion. This excludes activities deemed by the provider to be clinically essential, such as interacting with other clinicians directly involved in your care and executing routine duties such as providing refills, performing authorization requests for medications or specific treatments, and brief clinically-focused return of patient phone calls.

CANCELLATIONS AND NO-SHOWS

Due to HIPAA regulations, privacy, and confidentiality, patient sessions must take place in a confidential and quiet therapeutic space. If the patient's location is not suitable for the appointment, the session will end and be marked as a late cancellation and charged a \$50.00 fee for commercial insurance and self-pay patients.

There is a 15-minute grace period for each session, after which, the session will be deemed a no-show and will result in a \$50.00 fee for commercial insurance and self-pay patients.

***Please note: The \$50.00 fee only applies to clients who are Self-Pay/Out-of-Pocket, Sliding Scale, and/or have Private/Commercial insurance. This fee must be satisfied before resuming services.**

For commercial insurance and self-pay patients: If you must cancel or reschedule an appointment, we require at least 24-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday. Any patient who misses a scheduled appointment without providing at least 24 hours of advance notice will be assessed a \$50.00 no-call no-show/late cancellation fee.

For Medicare/Medicaid patients: If you must cancel or reschedule an appointment, we require at least 24-hour notice (weekends not included). If your appointment is on a Monday, the

cancellation must be made by the same hour on the preceding Friday. Any patient who misses a scheduled appointment without providing at least 24 hours of advance notice will have the appointment marked as a no-call, no-show/late cancellation.

Patients are responsible for keeping all scheduled appointments. We utilize an electronic management record system that generates calls, texts, and/or email reminders of upcoming appointments. Session reminders are courtesy of the practice but are the responsibility of the patient. Concessions will not be made for missed sessions due to the lack of appointment reminders sent from the system.

Any patients who have two late cancellations or no-call, no-shows in a row within 30 days will result in being discharged from services, and referrals to outside providers being provided.

If a patient would like to return for services they may do so after 30 days by calling the office, understanding that the former provider may not have availability.

PAYMENTS

Full payments are expected at the beginning of each session unless we have agreed on other arrangements. We accept cash, personal checks, and major credit/debit cards. Checks should be made payable to "Innovative Treatment Centers, LLC." A \$50.00 service charge will be charged for any checks returned for any reason for special handling.

If payment is 60 days past due, we reserve the right to utilize legal resources such as collection agencies or small claims courts in order to obtain payment for services.

***All terms and fees are subject to change at any time. Innovative Treatment Centers, LLC. will notify clients immediately if any changes occur.

- ☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the related [consumer disclosure](#). (From the Patient Questionnaire)

Please print your name below:

Name: _____ Date: _____

- ☐ I am the parent/guardian of this patient

Please sign below:

Signature: _____