10395 Double R Blvd • Reno, NV 89521 | 775-525-SUGI | www.sugipsychiatry.com

GENERAL CONSENT FOR TREATMENT

PLEASE READ EACH SECTION IN ITS ENTIRETY.

CONSENT FOR TREATMENT

I, the undersigned or responsible party, hereby consents to treatment by Sugi Psychiatry and Wellness and all providers contracted with it, including examination, developing a treatment plan, administration of medication, and other treatment modalities as ordered by the physician or provider.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

My consent and authorization is hereby granted to Sugi Psychiatry and Wellness and it's contracted providers, to release to healthcare facilities providing subsequent care, my insurance companies, health maintenance organizations, preferred provider organizations, medical trust fund, medical plan, my employers self-funded medical plan, third party administrators, other third party payers (which pay or may possibly pay any portion of the charges for my medical/health care) and any of their authorized agents, my confidential health and medical information, including copies of my medical records as may be requested or necessary for, including but not limited to the verification of my treatment, quality assurance/improvement functions, utilization management, discharge planning, other medical audits or as necessary for Sugi Psychiatry and Wellness or any of my payors to comply will all applicable federal and state laws, rules and regulations, and accrediting bodies. This consent and authorization is ongoing, unless revoked by the patient in accordance with the paragraph below ("revocation of consent"). I hereby release and hold harmless on behalf of myself, my heirs, executors, assigns and administrators, Sugi Psychiatry and Wellness and its contracted providers, employees and agents from any and all liability or damage occasioned by such good faith release. I understand that I have the right to access my records, but psychotherapy notes are the exception under the law. I understand that there will be a charge of $0.60/page per Nevada State Law for copies of any medical records/PHI. See NRS 629.061.

REVOCATION OF CONSENT

I understand that I have the right to revoke this consent in writing, except to the extent that the organization and or its providers has already acted in reliance thereon. I also understand that I have the right to object to the use of my health information for directory purposes and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. The organization and/or its providers are not required to agree to the restrictions requested and, in any event, may release records to subsequent medical providers when deemed necessary and important for the continuing care of the patients.

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included. I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

TELEMEDICINE INFORMED CONSENT

By signing this agreement, I give my consent to receive telemedicine services from Sugi Psychiatry and Wellness. Telemedicine is the delivery of medical services using interactive technologies (use of audio, video or other electronic communications) between a provider and a patient who are not in the same physical location. The interactive technologies used in telemedicine incorporate network and software security protocols to protect the confidentiality of patient

information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Equipment, Technology and Software Security Protocols:

- I will need access to, and familiarity with, the appropriate equipment and technology in order to participate in the service provided.
- ***I am using my own equipment*** to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.
- Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. The electronic systems are HIPAA-compliant.

Risks, Benefits & Limitations:

- This service is provided by technology {including but not limited to video, phone, text, apps and email) and does not involve direct face to face communication.
- These services rely on technology, which allows for greater convenience in service delivery.
- There are risks in transmitting information over technology that include, but are not limited to breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
- I understand that telemedicine is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.
- Among the risks that are presently recognized is the possibility that the technology will fail before or during the telemedicine service, that the transmitted information in any form will be unclear or inadequate for proper use in the service(s), and that the information will be intercepted by an unauthorized person or persons.

MISSED APPOINTMENTS

Keeping scheduled appointments is an important part of your treatment. Sporadic attendance hinders the efforts of our providers trying to help you, and it limits the effectiveness of your treatment. Missed appointments are not only a loss for you, but also to your provider and other patients that could have been seen. Our policy is to charge a no-show fee for missed or late cancelled appointments. Appointments cancelled less than 24 hours prior to your scheduled visit are considered late cancellations. Missed appointments and/or late cancellations will be assessed a no-show fee starting at $50.00 (subject to change). **This fee must be paid in full before we can reschedule an appointment for you, and no refills on medications will be prescribed until the fee is paid.**

Sugi Psychiatry and Wellness understands that emergencies arise and our staff will continue to do their best to accommodate everyone in an urgent situation. As a courtesy to our patients, our office staff will remind patients of their appointments via telephone call and/or email prior to their scheduled visit. Please make sure that we have your current phone number and email address on file, and that you have not opted out of automated text and email appointment reminders. Multiple no-shows/late cancellations (usually 3 or more) may lead to termination of care or referral to another provider.

PAYMENT

I understand that payment is expected at the time of my visit. Sugi Psychiatry and Wellness accepts cash and credit cards. Payment plans are available for large balances at the sole discretion of our billing department, and are subject to approval by clinic management.

PRIVACY

I agree to maintain the confidentiality of all other patients of the clinic. Our staff will maintain your confidentiality by not acknowledging you outside of the clinic unless you first acknowledge them.

MEDICATION REFILLS

If I need a medication refill and it is not time for me to be seen, I understand that I should **login to my patient portal account and send a refill request to my provider preferably 5-7 days prior and no less than 48 hours before running out of medication.** This will allow time to obtain authorizations that may be needed and make any changes that may be required. If you missed your last appointment, your provider may require an office visit prior to refills being authorized. **If you have not been seen by a provider within 3 months, we require an appointment to be scheduled** in order to receive a bridge refill (up to 2 weeks qty) to last until you can be seen by a provider.

CONTROLLED SUBSTANCES

I understand that I must sign Sugi's ***Controlled Substances Treatment Agreement*** to receive controlled substance prescription(s) from the clinic. This agreement must be updated annually. Refusal to sign the Controlled Substances Treatment Agreement will result in a change of treatment plan to exclude use of controlled substances.

I understand that before prescribing any controlled substances, my provider is required by law to check a profile maintained by the Nevada Board of Pharmacy which keeps track of all controlled substances dispensed in Nevada. I further understand that if my profile contains any irregularities such as excessive number of prescriptions, getting prescriptions from multiple providers, or early refills, my provider will not prescribe any controlled substances for my safety.

I understand that I must be examined in person by my provider before starting any new controlled medication(s) or being provided with any additional refills for controlled medication(s). **I agree to attend an in-person appointment every 30 days to continue receiving refills of any controlled medications.** I understand that I am required to comply with drug/alcohol/pregnancy testing to continue receiving my controlled medication(s). I understand that failure to do any of the above may result in delay or discontinuation of my controlled medication prescription(s).

I agree to keep track of my available doses remaining so as not to run out of my medication(s) between appointments. I understand that if I do run out of my controlled medication(s) and am not able to get into my provider in a timely manner or develop any subsequent discomfort, I will present to my local urgent care, emergency room, primary care provider, or detox center for evaluation and treatment as withdrawal from controlled substances can be very uncomfortable and possibly life threatening.

Failure to comply with controlled substance clinic policy may lead to dismissal from the practice.

DUTY TO REPORT
Sugi Psychiatry and Wellness has a legal obligation to report to authorities if they believe a child, disabled person, or elderly person is being abused or neglected. Sugi Psychiatry and Wellness has a legal obligation to report to authorities if they believe you are an imminent danger to someone else, or an imminent physical, mental or emotional danger to yourself.

PATIENT AND VISITOR CODE OF CONDUCT
Patients, visitors, and caregivers are expected to address providers, staff, and other patients in a respectful manner. Physical and verbal abuse towards providers and staff will not be tolerated and may lead to dismissal from the practice. **Su**gi Psychiatry and Wellness will provide 30 days of medication refills upon dismissal.

EMERGENCY CONTACT
In the case of an emergency, call 911 or go to your local emergency room. If you are suicidal, you can call the Crisis Call Center at 800-273-8255.

In the case of an emergency situation, or if I am deemed a threat to myself or someone else, I give the staff of Sugi Psychiatry and Wellness permission to speak with:

_____	_____	_____
Name	*Relationship to Patient*	*Phone #*

CELLULAR DEVICE OPT-IN CONSENT & INDEMNITY PROVISION
I expressly consent to receiving calls and/or SMS/text messages on my cellular device placed by Sugi Psychiatry and Wellness, its affiliates, business associates, and/or Messages from its service providers, from an automatic telephone dialing system and/or use of artificial or prerecorded voice, including, but not limited to, for the purpose of appointment reminders, office closure announcements, servicing my account, payments in billing, or collecting any amounts I may owe. I understand that this could result in charges to my data plan. I understand that SMS/text messages and cell phone messages carry certain risks. For example, messages may be sent in unencrypted form. They could be received by others if they have access to my device or if my messages are sent to another device. I agreed to notify Sugi Psychiatry and Wellness immediately if I change or obtain a new cell phone number, or no longer maintain the cell phone number provided in this provision, and especially acknowledge that I may be held liable for failure to do so as outlined below.

I agree to indemnify and hold Sugi Psychiatry and Wellness , its officers, agents and employees harmless from any liability, loss or damages, including but not limited to, attorneys fees that may suffer as a result of claims, demands, costs or judgments against Sugi Psychiatry and Wellness arising out of alleged violations of the telephone consumer protection act or similar laws, resulting from auto-dialed, SMS/text, artificial or pre-recorded voice calls placed to a assigned cell phone number(s), originally belonging to me or which I provided to the clinic, but of which I failed to timely notify the clinic that such number(s) was no longer assigned to me.

By signing this ***General Consent for Treatment*** agreement, Patient or Patient's Guardian, hereby attests that he/she has read, understands, and agrees to comply with this agreement. I understand that if I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

_____	_____
Patient Name	*Patient Date of Birth*
_____	_____
Signature	*Date*
_____	_____
Responsible Party Name (If other than Patient)	*Relationship to Patient*