CLEARCONNECT HEALTH SERVICES
1320 CENTRAL PARK BLVD STE 200
FREDERICKSBUR VA 22401

540.300.1091
INFO@CLEARCONNECTMH.COM
WWW.CLEARCONNECTMH.COM

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name:_____ Date of Birth:_____

I. CONSENT FOR CARE:

I authorize ClearConnect Health Services LLC ("ClearConnect"), psychiatric mental health nurse practitioners, psychiatrists, the licensed marriage and family therapists, mental health counselors, social workers and any other mental health practitioners employed by or contracted with ClearConnect (each, a "Provider") to provide behavioral health care for me, including mental health counseling sessions, psychiatric medications, evaluations, treatments, care management, and/or related services within the scope of each Provider's professional scope of practice and/or related services (collectively, "Behavioral Care"). The scope of this consent includes discussion of my Behavioral Care between Provider(s) and other health care professionals for purposes of care and treatment. I understand that I may withdraw this consent at any time by making a request in writing.

II. GENERAL CONSENT FOR CARE ACKNOWLEDGMENT:

I acknowledge that I have been informed about, understand and have been given the opportunity to ask any questions regarding the following information:

In providing Behavioral Care, the Provider(s) will provide comprehensive behavioral and psychological health care, evaluation, and treatment within each Provider's professional scope of practice.

The goal of the Behavioral Care services is to monitor and manage my behavioral and psychological conditions and health status.

Any risks associated with Behavioral Care services depend upon my specific diagnoses and health status. The Provider(s) will provide me with additional information about any risks associated with my individual treatment and care.

Benefits include convenient access to mental health providers who can assist in monitoring and managing my behavioral health conditions and overall health status.

My Provider will recommend Behavioral Care when my Provider(s) believes that t he benefits exceed the risks of such Behavioral Care.

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I acknowledge that Behavioral Care is not an exact science and there are no guarantees as to the results of any consultations, evaluations, treatments, or services that may be provided to me.

The nature and purpose of the Behavioral Care and expected benefits and potential complications (from known and unknown causes), likelihood of achieving goals, attendant discomforts, and relative risks that may arise from the proposed Behavioral Care, as well as possible alternatives to the proposed Behavioral Care, potential problems that may arise in the recuperative period, along with the relevant risks, benefits and complications of the alternatives, including the risk and consequences of no treatment have been fully explained to me

III. CONSENT FOR TELEMEDICINE (IF APPLICABLE):

Telemedicine Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations (the "Telemedicine Providers") to share individual patient medical information for the purpose of improving patient care ("Telemedicine"). The information may be used for diagnosis, consultation, treatment and/or follow- up and may consist of:

- Patient medical records and/or medical images (i.e., store and forward);
- Live two-way audio and visual communications; and
- Output data from medical devices and sound and video files (i.e., remote patient monitoring).

Electronic systems used will incorporate security protocols and safeguard measures to protect t he confidentiality of patient identification and data and to ensure its integrity against corruption.

Expected Benefits

- Improved access to medical care by enabling a patient to remain at a remote site while the P rovider obtains test results and consults with Telemedicine Providers at distant/other sites.

- More efficient medical evaluation and management.
- Expertise of a distant specialist Telemedicine Provider.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telemedicine, including, in rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the Telemedicine Provider; delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment, which could result in the Telemedicine Provider's inability to complete the evaluation and/or prescription process; security protocols could fail, causing a breach of privacy of personal health

information; or a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

IV. CONSENT FOR TELEMEDICINE ACKNOWLEDGMENT (IF APPLICABLE):

I acknowledge that I have been informed about, understand and have been given the opportunity to ask any questions regarding the following information:

· A limited physical examination may take place during the Telemedicine services and I can ask the Telemedicine Provider to discontinue the interaction at any time. Some parts of the exam may also be conducted by individuals at my location at the direction of the Telemedicine Provider and others may be present to operate the equipment.

· The laws that protect privacy and confidentiality of medical information also apply to Telemedicine services.

· All existing laws regarding patient access to and copies of health records apply to the Telemedicine services. I have the right to inspect all information obtained and recorded in the course of the Telemedicine services, and may receive copies of this information for a reasonable fee.

· I understand that Telemedicine may involve electronic communication of my personal medical information to other medical practitioners and ancillary service providers.

· I understand that I have the option to withhold or withdraw my consent for the use of the Telemedicine services in the course of my care at any time, without affecting my right to future care or treatment.

V. NETWORK PARTICIPATION AND ASSIGNMENT OF BENEFITS:

I hereby, irrevocably, assign to ClearConnect all medical insurance benefits and payment, and all rights and obligations, to which I am entitled (or have actually received), whether it be from a private, government or any other third-party payor (each, an "Insurance Payor"). I authorize and direct my Insurance Payor to remit payment directly to ClearConnect for Behavioral Care rendered to me.

Subject to applicable law and the terms and conditions of any applicable contract between ClearConnect and a third-party payer, and in consideration of all Behavioral Care rendered or about to be rendered to me, I agree to be financially responsible and obligated to pay ClearConnect for any balance not paid, pursuant this consent. I agree to assist the ClearConnect in its efforts to obtain payment for any Behavioral Care from any Insurance Payor. However, I fully understand that it is ultimately my responsibility to obtain any and all required authorizations, referrals and/or precertification(s) for any and all Behavioral Care. If my insurance plan has a pre-existing conditions clause, or requires an authorization or referral and I do not obtain one for the Behavioral Care services, I understand that I am responsible for all fees and payments associated with any and all Behavioral Care, subject to applicable law.

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I hereby appoint ClearConnect as my authorized representative (my "Authorized Representative") with the power to: (a) file and process medical claims with the Insurance Payor; (b) file appeals and grievances with the Insurance Payor;

(c) discuss or divulge any of my personal health information with any third party, including the Insurance Payor;

(d) institute and pursue on my behalf any claim, right or cause of action, including any necessary litigation and/or complaints against the Insurance Payor (even to name me as a plaintiff in such action); (e) act with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the Behavioral Care services, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

VI. INFORMATION PRACTICES:

I authorize ClearConnect and its agents and representatives to furnish and/or release any information, with the exception of any psychotherapy notes, acquired in the course of my Behavioral Care to insurance carriers concerning my diagnosed condition(s) and treatment (including information about substance abuse, mental health services, or HIV, if applicable) necessary to process my insurance claim(s), and to allow a photocopy of my signature to be used to process my insurance claim(s) for the lifetime of the claims. I authorize any holder of my medical information to release to ClearConnect and its agents and/or representatives any information needed to determine my insurance benefits and/or coverage. This authorization will remain in effect until revoked by me in writing.

VII. Consent to Use of AI Scribe Technology

I acknowledge that ClearConnect may utilize an AI-powered scribe system during my Behavioral Care sessions to assist with clinical documentation. This system may record and transcribe portions of the session in real time. I understand that any data collected by the AI scribe is handled in accordance with all applicable federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). Appropriate safeguards are in place to protect the confidentiality, integrity, and security of my protected health information (PHI). I consent to the use of this technology as part of my care and understand that I may withdraw this consent at any time by providing written notice.

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Photocopies/electronic transmissions/faxes of this consent and any signatures are to be considered as valid originals.

MY SIGNATURE BELOW INDICATES THAT I VOLUNTARILY AGREE TO ALL OF THE ABOVE AND THAT THE NATURE OF THIS CONSENT WAS EXPLAINED TO ME AND THAT I HAD THE OPPORTUNITY TO ASK ANY AND ALL QUESTIONS REGARDING THE ABOVE.

I acknowledge that I was offered a copy of the ClearConnect Privacy Practices.

Client Signature:_____ Date:_____

Parent/Guatdian Signature:_____ Date:_____

(For minor)