Treatment Agreement

WellMind with Dr. Michael McGee (and associates)

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Treatment Agreement

IMPORTANT *Please keep a copy of this document in a safe place for future reference.*

Confidentiality

In general, the law states that all communications between a mental health practitioner and his/her patients are confidential. Any information shared requires your verbal or written permission. You should be aware, however, of the following exceptions to the professional responsibility for maintaining confidentiality:

1) In some child custody or adoption proceedings;

2) If you were to make your own mental or emotional health an issue in a court case;

3) In circumstances in which, to the best of our professional judgment, we believe there is a chance you may harm yourself or another person;

4) If we have reason to suspect a child or elderly person is being abused;

5) For you to obtain third party reimbursement, we will have to provide your insurance company with a diagnosis. We may also need to share information about your clinical status, your treatment plan, and your response to your treatment;

6) If your account is overdue and arrangements for payment have not been negotiated, a collection agency will be provided with dates of service, type of service provided, and total amount due.

If any of the above circumstances were to occur in the course of our work together, we would try to remind you of our legal obligations and discuss the situation with you before taking action.

Clinical staff may consult with a colleague about your work together, who is bound by the same laws of confidentiality as we are. You agree to provide your unrestricted and open-ended consent for your clinician at WellMind to speak with any of your other therapists, doctors or other caregivers as long as you are under our care.

When treating adolescents, we discuss general issues with parents. However, we discuss the specifics of treatment only with the adolescent's permission.

Fees

Standard Fees

Service	**Psychiatrist Fee**	**NP/PA Fee**
Initial Visit Fee	$540 (80')	$465 (120')
50-minute visit	$300	$250
25-minute visit	$180	$150
Group psychotherapy session	$100	

Other fees: Telephone calls, email messages, other activities (such as report generation, legal work, time to obtain medication insurance authorizations, etc.)	$300/hour, billed in five-minute increments, (no charge for calls or work less than five minutes)	$300/hour, billed in five-minute increments, (no charge for calls or work less than five minutes)

Payment Policy

You must pay your balance in full at the time of service. Payment must be by credit card, cashier's check, or money order in advance of your session. We always require an active/valid credit card or debit card to be on file. We do not take personal checks. Failure to pay your account balance will result in suspension of your treatment until any balance due is paid.

Cancellations

We do not charge for canceled appointments provided you give a minimum of one business day's notice. We do charge full fee for cancellations with less than one business day's notice. We make exceptions to this policy only in extreme circumstances beyond your control. We may charge less that the full fee if our provider is billing your insurance and your insurance has restrictions on cancellation fees. By signing this agreement, you signify you agree to and understand that we may terminate your treatment for one or more late cancellations.

Missed Appointments

We charge your full fee for missed appointments, except when prohibited by your insurance (when billing your insurance for services). By signing this agreement, you signify you agree to and understand that we may terminate your treatment for one or more missed appointments.

Health Insurance

Some of our staff may accept your health insurance. If we do not accept your health insurance, we will provide you with statements for insurance reimbursement.

Emergency Coverage

We do not provide emergency coverage. In an emergency, go to your nearest emergency room or call 911.

Patient Responsibilities

You understand that we reserve the right to discontinue your treatment if, in our professional judgment, we do not feel your treatment is helpful to you. You agree to follow through with treatment plans we agree on, and to let your clinician know if you feel your treatment is not helpful and needs to be changed. You agree to take responsibility for your healing and growth, and to take an active role in engaging in wellness practices that promote your well-being as agreed as part of your treatment plan.

You enter into this treatment with the understanding that we will work together to maximize your well being. You will let your clinician know if you are ever feeling unsafe so that we can work together to prevent any harm befalling yourself or others.

You understand that we may end your care if we find that you have:

1. Given or sold your medications to another person;
2. Taken you medications other than as prescribed;
3. Not paid your bill;
4. Done anything that violates this treatment agreement.

You understand that treatment requires honesty. No one lives life perfectly or does recovery perfectly. You need not ever experience any shame in your treatment. You understand that we will never judge you. You understand that mistakes are best to be used as opportunities for learning and growth. Out of your own commitment to your healing and recovery, you agree to be honest, knowing that we will not judge you and your treatment will not be jeopardized. You understand that we may end your treatment if you are not honest, as this can seriously harm your treatment.

If you are struggling with addictions, you agree to make complete recovery from *all* addictions (including smoking) a treatment goal. Failure to work on your recovery may jeopardize your treatment if addictions are causing you significant harm.

You agree to call your therapist if you are not doing well or are in trouble. You understand that it is your responsibility to reach out and ask for help from your therapist.

You understand that you must attend sessions reliably and on time. Attending sessions late or missing appointments may result in ending your treatment.

Medications

You understand that we do not provide refills for controlled medications before they are due under any circumstances. You understand that we will not refill a controlled medication if it is lost or stolen. You must take care not to lose your medications or prescriptions. You agree to guard your medications carefully, and to store them in a secure place, such as a safe, away from access by children. If you are on a medication that creates physiological dependence, you understand that if you lose your medication you may go into withdrawal until you see your clinician again. We will provide comfort medications for you to help sustain you until your next appointment.

We will provide prescriptions for controlled medications to last until your next appointment and generally will avoid giving refills for controlled medications between appointments. We may not prescribe medications to you if you are abusing alcohol or illicit drugs in a way that jeopardizes your safety.

You agree to take your medications exactly as prescribed, and not make any changes without consulting your clinician. You agree to not give or sell your medication to anyone, or to take anyone else’s medications.

You agree to let your clinician know what other medications you are taking from other prescribers at all times. You agree to inform your clinician of any changes to your medications. You agree to not obtain any psychiatric medications from any prescriber other than your clinician.

You understand that we periodically perform pill counts on controlled medications that we prescribe. You agree to provide a pill count within 24 hours of random telephone or email requests for a pill count session. You agree to make your medications available for counting the number of pills in your bottle(s). You understand that failure to comply will be considered an indicator of medication mismanagement and may jeopardize your treatment.

You understand, that if you are recovering from an addiction, you may be called periodically to do random drug screens. You understand that you must complete these within 24 hours in order to continue your treatment.

If you are taking a controlled medication for treatment of an addiction, you understand that drug screens are required with every visit. If you fail to provide a drug screen, you understand that you will not be prescribed any controlled medications, but may receive comfort medications for withdrawal, if indicated, until you are able to provide a drug screen.

You understand that if you are receiving medications to treat an addiction, you must ACTIVELY work on your

recovery to receive treatment, as medications are only a small part of the process of healing and recovery. We will work out together an individualized recovery program for you according to both your needs and your preferences.

If receiving controlled medications for an addiction, you agree to be seen at least once every one to eight weeks, at your clinician's discretion, based on how well you are doing. We will likely see you even more frequently if you are not stable or are new to treatment. If you are not on controlled medications, you agree to be seen at least once every 3 months if you are stable.

If you are taking a sedating medication, such as a benzodiazepine or buprenorphine, you understand that mixing these medications with other sedatives, such as other benzodiazepines, barbiturates, alcohol, or other drugs of abuse can be dangerous. You also understand that a number of deaths have been reported, for example, among individuals mixing buprenorphine with benzodiazepines.

Drug Testing

You understand that drug testing is solely to confirm an accurate assessment of your current recovery status. You must do your drug screen when asked. Not doing your drug screen when asked will be considered to be evasion. You may occasionally receive a call to do a random drug screen. When you do, you will need to do a drug screen by the end of the next day. You understand that your treatment is not jeopardized by a positive drug screen. If we prescribe controlled medications to you for a substance use disorder, you agree to submit to drug testing. This may be scheduled or random. You agree to submit to random drug tests within 24 hours of a request and understand that failure to do so may result in termination of your treatment. You understand that any attempt to falsify or adulterate a drug screen may also result in termination of your treatment. You understand that we cannot prescribe your medication to you if you have not completed your drug test and/or we do not have the results.

Electronic Communications

You may email or text your clinician for brief questions. You understand that emails and texts are not secure. You understand and agree to not use emails or texts for treatment purposes.

For sensitive clinical information, you agree to call us if you are not comfortable with text or email.

We conduct much of our practice using telepsychiatry. You understand that to be treated with telepsychiatry you must reside in a state where your clinician is licensed in order to receive treatment from us. You must provide us with proof of your identity and address with a copy of a photo ID and a piece of mail with your residence address on the envelope.

Turn around time for all electronic communications is generally 1-3 business days. we do not monitor these when we are away and have no coverage to monitor them. For urgent clinical matters, you agree to call your clinician, or their coverage when they are away.

Telephone Communications

We generally respond to telephone calls within one business day.

Medical Records.

You have a right to view your medical record. We have the right, based on your clinician's clinical judgment of your best interests, to require that we review your record together, or to provide you with a summary of your record rather than the original record itself. We are required by law to note in your record any corrections or additions that you may request.

Authorization, Acknowledgement and Release

With your signature below, you authorize and signify the following:

- You have read, understand and consent to the policies in this treatment agreement;
- You authorize the release of any medical information necessary to process insurance claims and give unconditional consent for your clinician to speak with any of your other therapists, doctors or caregivers while you are under my care; and
- You authorize payment of medical benefits directly to WellMind with Dr. Michael McGee (and associates) for services rendered.

_____	_____	_____
Patient or Guardian Signature	***Print Name***	***Date***

X _____

Signature Certificate

Document name: Treatment Agreement

Unique Document ID: 612D7154FA0D8B672519DC6A213355CF8C0C1E48

LEGALLY SIGNED USING WPesignature
Build. Track. Sign Contracts.

Timestamp	Audit
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This audit trail report provides a detailed record of the online activity and events recorded for this contract.