# Well Nourished, LLC

12157 W Cedar Dr Suite 200
Lakewood, CO 80228-2105
Phone: 720-513-1215
Fax: 720-547-6960
Email: office@wellnourishedpsych.com
Website: wellnourishedpsych.com


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## Consent Forms

All clients or the client's legal guardian will be provided with a copy of this written policy. Below includes the following:

- **Registration procedures**
- **Billing policies**
- **Medication refill policy**
- **No show/cancellation policy and procedures**
- **Appointment Reminder Policy**
- **SMS policy**
- **Controlled substance policy**
- **Termination of care policies and procedures**
- **Patient Consent for Use and Disclosure of Protected Health Information**
- **Notice of Privacy Practices**

These must be agreed to at the time of registration (prior to the first visit), or as a more current version is available. We cannot move forward with treatment if consent forms are not signed per the termination of care policies and procedures below**.** The client or their legal guardian will accept the terms and conditions by signing an acknowledgment of all clinic practices.

## Registration Procedures

Well Nourished LLC strongly advises that clients verify insurance eligibility prior to your visits. IT IS THE PATIENT/GUARDIAN'S RESPONSIBILITY TO VERIFY INSURANCE COVERAGE/BENEFITS. Any changes in insurance, deductibles, and/or copays are the responsibility of the client. Charges not paid by insurance are the responsibility of the client and will be billed after service.

Co-pays, deductibles, or any outstanding amounts may be collected prior to appointment services. A follow-up appointment will not be scheduled if there is a balance due, unless the provider determines that the client is in an emergency situation, in which case, a follow-up appointment will be provided. and the client will be given a 30-day written termination notice.

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## Billing policies

Well Nourished LLC is accepting self-pay clients who are not insured or opt to see us without insurance at the following 2024 rate:

Intake appointments: $250
Follow up visits: $100 - $150 (based on complexity and time)

*All payments for services are due and payable prior to or during the visit. Failure to pay for services is subject to the termination of care policies and procedures below.

If a payment is greater than 90 days past due, we reserve use of legal resources such as collection agencies or small claims courts in order to obtain payment for our services.

Well Nourished LLC enables your credit card, debit card, or health savings account card to be stored within our billing system and processed through Stripe. The credit card number is securely stored on a remote server and is not visible to us. When checking you in for your appointment, payment is due at the time services are rendered. At this time, we would request your permission to store your card on file, or to use the card on file, if you have already requested that we store a card on file. If you permit us to store your credit card, we can use it for future payments including when your insurance company denies the claim.

By signing here, you are consenting for Well Nourished LLC to store a payment card on file for payments.

_____ _____
Patient/Personal Representative Signature Date

_____
Printed Name

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## Medication refill policy

**Medication refill policy**
Patients must legally be established patients of Well Nourished LLC to be prescribed medications and have signed HIPAA consent before being seen by the provider.

Due to the volume of requests, **as of September 1st, 2023, we require 3 days minimum to process prescription renewals and requests**. Please note that patients are responsible for knowing when medications need to be refilled. No early refills will be accepted.

If a client has not been seen within the previous 90 days, no Schedule II Controlled medications will be prescribed/refilled. Clients must also have consent of random drug screening agreement on file. ALL patients seeking/obtaining controlled substances MUST be strictly compliant with our Controlled Substance policy, see below.

Starting September 1st, 2023, we will continue be in strict compliance with the updated DEA requirements and recommendations. All patients who are prescribed medication(s) that are considered a controlled substance (schedule II- V) **are required to attend an in-person appointment at least 3 times annually.** If this applies to you, your provider will discuss options with you during your first and subsequent visits.

## No show cancellation policy and procedures

We will make every effort to accommodate a late patient within the same day, whenever possible. Please be on time to appointments to avoid late fees or rescheduling of appointments.

Clients who fail to show for an appointment or do not provide notice within the same business day will be assessed a NO-SHOW FEE of $50 for follow up appointments and $75 for new patient appointments.

The office staff can be reached at all times for canceling and rescheduling appointments at (720) 513-1215 or via email at office@wellnourishedpsych.com A voicemail may be left after business hours which are 9am - 5pm Monday to Thursday and 9am - 12pm on Friday.

Reminder calls and emails through our automated system (Kareo) are a courtesy and only occur reliably

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when your email address and phone numbers on file are correct. It is the client's responsibility to ensure they are present for their scheduled appointment(s) or to provide notice of their cancellation. Please respect the time of the provider as they have set aside this time for you.

If a client has a second no-show, at the provider's discretion, the patient may be terminated from care, at which time the patient would receive a certified letter informing them that care has been terminated.

## Appointment reminder policy

In compliance with the Telephone Consumer Protection Act, we require written consent to send text or voicemail confirmation of your appointments. It is the patient's responsibility to ensure that the phone number provided to Well Nourished LLC is the preferred and direct phone number for the patient or legal guardian.

By signing this consent, THE PATIENT OR GUARDIAN AGREES TO ALLOW TEXT, VOICEMAIL, AND/OR EMAIL APPOINTMENT REMINDERS to be sent to the primary phone number and email address on file.

_____ _____

Patient/Personal Representative Signature Date

_____

Printed Name

## SMS Policy

This policy is to inform you that EMAIL and standard SMS messaging (TEXT) are not confidential methods of communication and may be insecure. Because of this, there is a risk that email and standard SMS messaging regarding your medical care might be intercepted and read by a third party. We make every attempt to communicate as little health information as possible over this form of messaging to keep your information secure. Use of the SPRUCE messaging platform is a safeguard we have in place to store communication securely. You have access to secure messaging through Spruce in addition to standard SMS through this platform. You can opt in at any time throughout your care with Well Nourished LLC.

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By signing, you consent that your preference is to have providers and staff at Well Nourished LLC communicate with you by EMAIL or standard SMS messaging (TEXT) regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

_____ _____

Patient/Personal Representative Signature Date

_____

Printed Name

## Controlled Substance policy

We will, under no circumstances, prescribe controlled medications for a patient unless they agree to **random, routine drug testing.** This will be required either in clinic, at a designated testing site or via review of drug screening through an outside entity with required Release of Information on File. **This is a requisite for treatment with any controlled substances at our clinic.** Controlled medications are copious and can be identified in full at www.deadiversion.usdoj.gov/schedules/index.html.

As of September 1st, 2023, we will be in strict compliance with the updated DEA requirements and recommendations. All patients who are prescribed medication(s) that are considered a controlled substance (schedule II- V) are required to attend an in-person appointment at least 3 times annually. If this applies to you, your provider will discuss options with you during your first and subsequent visits.

Misuse or diversion of medication will not be tolerated. Well Nourished LLC reserves the right to dismiss the client in cases of misuse or diversion. Signs of misuse and diversion include but are not limited to:

- Requesting early refills of medication. There are NO early refills if medications are overused, abused, misused, lost or stolen.
- The medication is being prescribed by multiple providers for controlled substances or narcotics
- Inappropriate behavior towards staff and/or providers when discussing clinical advice of medication dosages and/or prescription based on clinical assessment.

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As clinicians, we are stewards of safe controlled substance prescribing. If there is a concern of diversion or misuse of a medication, we may require pill counts and additional urine drug testing. It is our mission and goal to safely and intentionally support you and your mental health. This is only used as a measure when absolutely needed to ensure safety and adherence to the agreed upon treatment plan. **We reserve the right to drug test any patient, at any time, for any reason, as our ability to prescribe is predicated on safe and appropriate prescribing practices. The safety of the client and staff is of highest importance.**

**NO controlled substances or stimulants will be provided as "bridge" scripts. You MUST keep your scheduled appointments in order to receive refills for these medications!**

**If insurance does not cover the cost** of the drug test required to prescribe the patient's controlled substance, **paying for the drug test is the responsibility of the patient**. However, the lab does have a discounted cash rate for such instances.

If drug testing performed reflects excessive or dangerous levels of alcohol metabolites, the provider reserves the right to discontinue controlled substances in the interest of patient safety and judicious prescribing. IF, AT ANY TIME, A PATIENT TESTS POSITIVE FOR A SUBSTANCE THEY SHOULD NOT BE TAKING, IS NOT BEING PRESCRIBED TO THEM, OR IS ILLEGAL OR ILLICIT, OR IS NEGATIVE FOR A CONTROLLED SUBSTANCE THEY ARE REPORTEDLY TAKING CONSISTENTLY, WE WILL NO LONGER PRESCRIBE CONTROLLED SUBSTANCES FOR THE PATIENT, AND THIS DECISION WILL NOT BE REVOKED.

By signing this consent, THE PATIENT OR GUARDIAN AGREES to and endorses understanding of this policy.

_____ _____

Patient/Personal Representative Signature Date

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Printed Name

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## Termination of care policy and procedures

Clients may terminate treatment at any time, if they so choose. Well Nourished LLC may terminate treatment for any of the following reasons:

- The provider determines that the clinic staff does not have the expertise to treat the client's problems or the provider determines that the client needs a higher level of care and that Well Nourished LLC doesn't provide the scope of services needed for the client.
- The client is failing to adhere to the treatment plan or practice policies. This includes misuse of prescribed medication, testing positive for illicit or non-prescribed substances, testing negative for medications the client is reportedly taking consistently, violating the controlled substance policy, failure to notify the provider of significant changes in condition, two or more no-shows, or multiple appointment cancellations that result in significant periods without treatment.
- Failure to pay outstanding charges on client accounts or failure to pay for services.
- Inappropriate behavior which include threats, derogatory language, abuse of staff, unprofessional conduct, and/or any disruption to the clinic. The mental health and safety of providers and staff is of high priority at Well Nourished LLC and any this clause in particular is taken seriously. Harassment is ILLEGAL no matter the format which includes in person, text, letter, and phone calls.

If the clinic terminates care, the client will be provided written notice including the reasons for the termination and referrals for alternative sources of treatment. Terminations are permanent. Terminated patients cannot resume care under Well Nourished LLC in the future.

Notice period will be 30 days UNLESS termination is due to non-adherence with the treatment plan, inappropriate conduct, or potentially dangerous behavior, in which case the client is in violation of this treatment contract and waived the notice period.

By signing this consent, THE PATIENT OR GUARDIAN AGREES to and endorses understanding of this policy.

_____ _____

Patient/Personal Representative Signature Date

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## Patient consent for use and disclosure of protected health information (PHI)

I hereby give my consent for Well Nourished, LLC to use and disclose protected health information (PHI) about me to carry out Treatment, Payment and Health care operations (TPO). (The Notice of Privacy Practices provided by Well Nourished, LLC describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Well Nourished, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Well Nourished, LLC at office@wellnourishedpsych.com or mailed to the office at 12157 W Cedar Dr Suite 200, Lakewood, CO 80228-2105.

With this consent, Well Nourished, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. Well Nourished, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Well Nourished, LLC may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Well Nourished, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this.

By signing this consent, THE PATIENT OR GUARDIAN AGREES to and endorses understanding of this policy.

_____ _____

Patient/Personal Representative Signature Date

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# NOTICE OF PRIVACY PRACTICES

**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.**

If you have any questions about this Notice of Privacy Practices ("Notice"), please contact **Hope Marie Manning, PA-C, CAQ-Psych,** who acts as our Privacy Officer, at **telephone number 720-513-1215.** This Notice is effective as of **Jan 1st, 2024** and applies to all Protected Health Information in our hands and created on or after this effective date, whether generated by us or received from other health care providers. This Notice is subject to change from time to time by the Practice and any such revisions will be posted in our offices.

## WHO WILL FOLLOW THIS NOTICE

The Practice offers health care services that are covered by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations. This Notice describes the information privacy practices that the Practice follows, and the Practice is required by law to abide by its terms.

## YOUR HEALTH INFORMATION

This Notice applies to any Protected Health Information (as defined below) that the Practice prepares, receives, or maintains concerning your health, health status, and the health care and services you receive from the Practice. This Notice is given to you in accordance with HIPAA and its regulations.

The Practice is required by law to give you this Notice and to preserve the privacy of the Protected Health Information which we maintain. This Notice will tell you about the ways in which we may use and disclose your Protected Health Information and describes your rights and our obligations regarding the use and disclosure of that information. This Notice does not apply to any information which is not Protected Health Information or which the Practice does not prepare, receive, or maintain. The Practice will observe the confidentiality of such other information as required by law and will abide by the then-current Notice. We are also required

by law to notify you following a breach of unsecured Protected Health Information.

INTRODUCTION

At the Practice, we are committed to treating and using Protected Health Information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your Protected Health Information.

## USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION IN TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

As detailed below, your Protected Health Information may be used by the Practice for these reasons:

- **TREATMENT, PAYMENT, OPERATIONS AND OTHER USES AND DISCLOSURES**

1. *Treatment:* The Practice may use and disclose your Protected Health Information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, we may coordinate your health care with a third party. For example, we may disclose your Protected Health Information to a pharmacy to fulfill a prescription for medication, to a radiology facility to order an X-ray, or to a physician or other health care professional or facility who or which is assisting in your health care. In addition, we may disclose Protected Health Information to other health care providers related to the treatment provided by those other providers.
2. *Payment:* When needed, the Practice will use or disclose your Protected Health Information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended procedure or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, we may also disclose your Protected Health Information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, we may also disclose your Protected Health Information to another provider where that provider is involved in your care and requires the information to obtain payment.
3. *Operations:* The Practice may use or disclose your Protected Health Information when

needed for the Practice's health care operations for the purposes of management or administration of the Practice and for offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, we may use, as needed, Protected Health Information of patients to review their treatment course when making quality assessments regarding any specialized care or treatment. In addition, we may disclose your Protected Health Information to another provider or health plan for their health care operations.

4. *Other Uses and Disclosures:* As part of treatment, payment, and health care operations, the Practice may also use or disclose your Protected Health Information to: (1) remind you of an appointment; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

## USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

***Family/Friends:*** The Practice may disclose your Protected Health Information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose Protected Health Information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you have any objection to the use and disclosure of your Protected Health Information in this manner, please tell us.

## USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT YOUR AUTHORIZATION

***Research:*** Under certain circumstances, the Practice may use and disclose your Protected Health Information to approved clinical research studies. While most clinical research studies require specific patient consent for participation as a research subject, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

***Regulatory Agencies:*** The Practice may disclose your Protected Health Information to government and certain private health oversight agencies, such as the Colorado Department of Public Health and Environment, or the Colorado Physical Therapy Board for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations, and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

***Law Enforcement/Litigation:*** The Practice may disclose your Protected Health Information for law

enforcement purposes as required by law or in response to a court order or other process in litigation.

***Public Health:*** As required by law, the Practice may disclose your Protected Health Information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. For example, we are required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

***Workers' Compensation:*** The Practice may release Protected Health Information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

***Military/Veterans:*** The Practice may disclose your Protected Health Information as required by military command authorities if you are a member of the armed forces.

***Organ Procurement Organizations:*** To the extent allowed by law, the Practice may disclose your Protected Health Information to organ procurement organizations and other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

***As Otherwise Required or Permitted By Law:*** The Practice will disclose your Protected Health Information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse) or any other use permitted under HIPAA, its amendments, or regulations.

## USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:

Other than the circumstances described above, the Practice will not disclose your Protected Health Information unless you provide written authorization. An authorization is specifically required in most situations involving uses or disclosures of Protected Health Information for marketing purpose, for the sale of Protected Health Information, or for psychotherapy purposes. You may revoke your authorization in writing at any time except to the extent that we have already acted in reliance upon the authorization.

## YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION:

Although all records concerning your treatment obtained at the Practice are the property of the Practice, you have the following rights concerning your Protected Health Information:

- ***Right to Confidential Communications:*** You have the right to receive confidential communications of your Protected Health Information by alternative means or at alternative locations. For example, you may request that we contact you at work or by mail.

- ***Right to Inspect and Copy:*** You generally have the right to inspect and copy your Protected Health Information, except as restricted by your physician or other health care professional or by law. Further, if we maintain your health records on an electronic health

records system, you have the right to request an electronic copy of your health records.

- ***Right to Amend:*** You have the right to request an amendment or correction to your Protected Health Information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.

- ***Right to an Accounting:*** You have the right to obtain a statement of the disclosures that have been made of your Protected Health Information other than by your authorization, other than to you and other than for the purpose of treatment, payment, or routine operational purposes.

- ***Right to Request Restrictions:*** You have the right to request restrictions on certain uses and disclosures of your Protected Health Information. If we agree, we will abide by the restrictions. Additionally, if you (or anyone on your behalf besides a health plan) pay for the care or services at issue in full out of your own pocket, we are required to comply with your request not to disclose your Protected Health Information to a health plan, unless required by law to do so.

- ***Right to Receive a Copy of this Notice:*** You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.

- ***Right to Revoke Authorization:*** You have the right to revoke your authorization to use or disclose your Protected Health Information, except to the extent that action has already been taken in reliance on your authorization.

- ***Right to Notice of Breach of Security:*** You have the right to be notified in the event of a breach of unsecured Protected Health Information occurs.

- ***Right to Opt Out:*** You may be contacted for certain fund-raising purposes and you have the right to opt out of receiving such communications.

## THE PRACTICE'S RIGHTS

1. The Practice is allowed a reasonable time (typically 30 days) with which to comply with a patient's request to review or copy their health information. The Practice is allowed an additional reasonable period of time if the record is off site. The Practice may charge a fee for copying the health record.
2. Requests for examination and copying medical records are subject to the provisions of existing Colorado law, including without limitation all relevant rules, regulations, and policies of the licensing boards.
3. The patient will be supervised by the Practice staff during any in-person review of the record. Supervision is allowed and required to prevent the removal or altering of the medical record. The

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patient will not be charged for in-person examination of the records.

**THE PRACTICE'S DUTIES**

1. The Practice is required by law to maintain the privacy of confidential information and provide individuals with notice of its legal duties and privacy practices with respect to such information.
2. The Practice is required to abide by the terms of this Notice.
3. The Practice reserves the right to change the terms of its Notice from time to time and to make the new Notice provisions effective for all confidential information that it maintains.

**FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS:** If you have questions or would like more information regarding any of the rights listed above, please contact **Hope Marie Manning, PA-C, CAQ-Psych,** who acts as our Privacy Officer, at the telephone number on the first page of this Notice.

**IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED:** If you believe your privacy rights, as described in this Notice, have been violated, you may file a complaint with our office and/or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer as listed on the first page of this Notice. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or e-mailing OCRMail@hhs.gov. You will not be penalized or retaliated against for filing a complaint.

## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for the Practice.

_____ _____
Patient/Personal Representative Signature Date

_____
Printed Name