General Consent to Treatment
Informed Telehealth Consent
HIPAA Consent

Notice Regarding Confidentiality of Client Records

Federal and State Laws and regulations protect the confidentiality of client records maintained by Journey healthcare. Journey will not disclose any information identifying a client as a recipient of treatment services unless:

1. The client consents in writing; or
2. The disclosure is permitted by a good cause court order; or
3. The disclosure is made to medical personnel in a medical emergency; or
4. The disclosure is made to "qualified personnel" for audit or program evaluation. (for licensing and accreditation of the facility, those responsible for assuring compliance with the contract standards or provisions are "qualified personnel" in the Commonwealth of Pennsylvania, the Governor's council determines who "qualified personnel" is).

Client Rights

As a client of Journey, you are entitled to the following:

1. You shall retain all civil rights and liberties except as provided by law. No client shall be deprived of any civil rights solely by reason of involvement treatment.
2. Journey shall not discriminate on the basis of age, race, creed, ethnicity, national origin, marital status, sexual orientation, handicap, or religious preference.
3. You have the right to inspect your record. The Program Manager may temporarily remove portions of your record prior to your inspection when she/he determines that the information may be detrimental to you if presented. The reason for the removal will be documented as part of your record. The following procedure is to be followed when requesting review of your record:

    a. Submit a written request to a staff member stating the reason(s) you are requesting to review your record.
    b. Sign and date the request.

This request will be presented to the Program Manager, along with your record to the Program Manager. All such requests will be honored within 7 days. You may request a correction or removal, if the information is inaccurate, irrelevant, or incomplete. Appeal related to the retention or destruction of record contents are to be mediated by the Program Manager. You may submit rebuttal data or a memorandum to your record.

Services Provided

- Psychiatric Evaluation and Follow Up
- Individual and Group Counseling
- Family Therapy.
- Medication Assisted Treatment
- Teletherapy and Telehealth Services

Consent to Treatment

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this program. If I have medical coverage that will cover the cost of my treatment, I agree to provide Journey with the necessary documents which will allow them to bill my medical coverage provider
3. I agree to conduct myself in a courteous manner in the Journey Healthcare Program
4. I agree not to give any of my medication to another person for any reason.
5. I agree not to conduct any disruptive activities in the Journey Healthcare program.
6. I agree that my prescription can only be given to me at my regular treatment visit. A missed visit may result in my not being able to get my prescription until the next scheduled treatment visit.
7. I understand that my provider will not fill any prescriptions early if I run out of controlled substances before my scheduled refill or appointment.
8. I agree that the medication I am prescribed by Journey Healthcare is my responsibility and I agree to keep it in a safe, secure, place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree to present my medication the staff at Journey Healthcare at their request for random medication counts. When I am requested to bring my medication for a medication count, I agree to allow that medication to be stored by the program staff in a secure place.
10. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician. If I am prescribed another medication, I agree to disclose that information to the physician at Journey and present the medication at his/her request.
11. I understand that mixing respiratory suppressants such as Buprenorphine with other medication, especially benzodiazepines or alcohol can be dangerous. I also recognize that several deaths have occurred among persons mixing Buprenorphine and benzodiazepines (especially if taken outside the care of a physician or in higher than recommended therapeutic doses).
12. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
14. I acknowledge that I have a complete understanding of the risks of consuming alcohol while taking controlled substances.
15. In order to receive prescription of any controlled substances I agree to provide urine drug screen samples and breath alcohol tests if ordered by my provider.
16. I understand that violations of the above may be grounds for termination of treatment.
17. (*For Women Only utilizing buprenorphine Med Management Services*) Drugs of abuse such as opiates/heroin, cocaine and other stimulants, alcohol, benzodiazepines, nicotine, marijuana, have been shown to have substantial risks during both intoxication and withdrawal to pregnant women and their unborn children. These risks include but are not limited to preterm labor, low birth weight, placental tears or abruption, birth defects, sudden infant death syndrome, and abnormal cognitive /behavioral/motor development. If I become pregnant and have history of abusing opiates, I am aware that Subutex maintenance is offered at Journey Healthcare. I understand that Subutex is transmitted to the unborn child and may result in prenatal complications including physical dependency of the unborn child.

Client Responsibilities

During your treatment at Journey, you will be expected to adhere to the following:

1. Clients are expected to abide by all treatment recommendations made by treatment staff.
2. Clients who are unable to attend a scheduled appointment must call and speak directly with a staff member. All cancellations should be made 24 hours in advance or you will be charged a $50 no show fee for follow up appointments, a $75 no show fee for your initial individual therapy intake appointment and $100 no show fee for initial psychiatric evaluation appointment.
3. Please be on time. Any client more than 15 minutes late will have to reschedule for the next available appointment.
4. Clients may be asked to submit random breathalyzers or urine analysis screens if they receive a controlled medication prescription of any kind while in treatment or ordered by their treatment provider.
5. No violent behaviors or acts will be tolerated on Journey Healthcare property. No use of obscene language or gestures.

Payment Policy, Fee Schedule & Credit Card Authorization

Fees must be paid directly to the receptionist prior to your designated appointment. If payment is not received, then the visit will be re-scheduled for a later date. Payment must be received before you are seen by the provider. If you do not pay, you will be re-scheduled and you will not receive a prescription.

Journey Healthcare participates in some commercial insurance plans. It is your responsibility to alert us of any changes to your insurance. All insurance related copayments, coinsurance and deductibles are due at time of service. Should your insurance not cover a desired service offered by Journey Healthcare it is your responsibility to cover any service incurred. We accept all major forms of credit cards, cash and certified checks.

The fee schedule is posted in the main lobby of the facility and in your initial client handbook. If you need an additional copy you may request one and it will be given to you.

If you need an additional copy, you may request one.

I understand the full payment is required at the time of service by either cash or credit card.

I also understanding that the financial responsibility for services is mine, and that I must provide any information regarding active insurance to Journey Healthcare.

I understand that if the credit card charge is denied, I will be billed separately for the appointments. I understand that I must pay for any outstanding balance in full before receiving further services.

I agree to call and notify the receptionist in advance of my next scheduled appointment if my address, phone number, or responsible party has changed.

I agree to provide Journey Healthcare with an active credit card to bill during utilization of telehealth services or for any incurred balance.

I agree to keep an active credit card on file at all times. I agree to call and notify the receptionist if my credit card expires and will provide a current one prior to my next service.

The undersigned authorizes Journey Healthcare to charge account balances to the provided credit card for Services Rendered at Journey Healthcare.

Should any balance be open on your account at time of discharge or discontinued treatment the remaining balance shall be run in full. By signing below, I acknowledge and consent to the use of your credit card without signature on the charge slip, that this agreement will serve as an original and this credit card authorization.

Acknowledgement of Receipt of Client Handbook

I acknowledge that I have received a copy of the Journey Healthcare Client Handbook at the time of my admission and that I have been informed that I am free to ask questions about it at any point throughout my treatment. Fees were also discussed with me at the time of my intake.

Informed Consent Telemedicine Services

I understand that it is my obligation to notify Journey Healthcare of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify Journey Healthcare of the change in location.

I understand that it is my obligation to notify Journey Healthcare of any other persons in the location, either on or off camera and who can hear or see my sessions. I understand that I am responsible to ensure privacy at my location. I will notify Journey Healthcare at the outset of each session and am aware that confidential information may be discussed.

I agree that I will not record either through audio or video any of the sessions.

I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.

I am aware that alternative care options including in person visits are available for any services I receive.

I have been trained on how to use telehealth technology by Journey Healthcare.

Telehealth is NOT an emergency service. In the event of an emergency, I will use a phone to call 911.

To maintain confidentiality, I will not share my telehealth appointment link or information with anyone not authorized to attend the session.

I understand that either I or Journey Healthcare can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me.

I have read and understand this consent to treatment and the associated telehealth policies. By providing my signature I am acknowledging my informed consent to engage in Telehealth Virtual care services.

Emergency and Psychiatric Consent

I consent to allow Journey to procure for me in the event of a medical or psychiatric emergency and release Journey from all liability related to any injury which may occur during my treatment at this facility.

I have been offered a copy of this consent and: ___ Accept ___ Reject

This consent is subject to my revocation at any time. It will expire at the conclusion of my treatment stay. My signature indicates that I have been provided with and understand the above information regarding my rights, responsibilities and treatment.

_____ _____

Client Signature: Date:

HIPAA CONSENT FORM

This notice is effective as of_____/_____/_____.

I have read the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide Journey Healthcare with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Client's Signature: _____Date: _____

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients with a "Notice of Privacy Practice' statement.

Journey Healthcare

NOTICE OF HIPAA 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.

Journey Healthcare is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our clients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. For example, on occasion, it may be necessary to seek consultation regarding your condition from other health care professionals associated with Journey Healthcare.

Payment
We may disclose your health information to your insurance provider for the purpose of payment of health care operations. For example, as a courtesy to our clients, we will submit an itemized billing statement to you and/or your insurance carrier for the purpose of payment to Journey Healthcare for health care services rendered. The billing statement contains medical information, including diagnosis, date of condition and codes that describe the health care services rendered.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

Juridical and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a good cause court order or subpoena and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner or government benefits purposes.

Appointment Reminders
We may contact you for purposes of reminding you that you have an appointment for treatment at our office.

Change of Ownership
In the event that Journey Healthcare is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights
You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Journey Healthcare is not required to agree to the restriction that you request. You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication of delivery, upon your request. You have the right to inspect and copy your health information.
You have the right to request that Journey Healthcare amend your protected health information. Please be advised, however, that Journey Healthcare is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by Journey Healthcare. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Journey Healthcare reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Journey Healthcare is required by law to comply with this Notice.

Journey Healthcare is required by law to maintain the privacy of your health information and to provide you with notice of its' legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact the HIPAA Privacy Practice Officer by calling our office at the number listed in the Client Handbook.

HIPAA Disclaimer

Releases of information permitted by HIPAA regulations which are prohibited by the Federal and State Confidentiality Laws for substance abuse treatment, continue to be prohibited and will require the client's written consent.

Complaints

Complaints about your Privacy rights or how Journey Healthcare has handled your health information should be directed to the HIPAA Privacy Practice Officer at Journey Healthcare. If s/he is not available, you may make an appointment for a personal conference in person or by telephone within two working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS
Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201