CORE WELLNESS

Core Wellness, LLC

2833 Smith Ave #419
Baltimore, Maryland 21209 443-420-7379
Fax: 1-877-715-7229 Email: office@mycorewell.com

INFORMED & TELEHEALH CONSENT

Welcome to our practice, we look forward to working with you to provide effective clinical counseling services that address the issues and concerns that brought you or your loved one to therapy. This form describes your rights, mutual expectations, HIPAA compliance, policies, informed consent, expectations, limits and risks of therapy and confidentiality mandated by law. We welcome any questions, at any time.

The content of a counseling intake, assessment and all sessions are fully confidential. Verbal information and written records about a client cannot be shared with another party without written consent of the client or his/her legal guardian. It is the policy of Core Wellness, LCC (henceforth "CW" or "we") not to release any information about a client without a signed release of information. Only staff of CW, including but not limited to, therapists, medical staff, billers and secretaries, are aware of your attendance or relevant client details. Noted exceptions of confidentiality are the following:

1) Duty to Warn and Protect

As licensed health care providers, if a client discloses intentions or a plan to harm him/herself or another person, we are required by law to warn the intended victim and report this information to the police. In cases in which the client discloses or implies a plan for suicide, we are required to notify legal authorities and make reasonable attempts to notify the client's family.

2) Abuse of Children and Vulnerable Adults

If a client states/suggests that he or she is abusing a child or vulnerable adult or has abused such a person, is in danger of being abused, or was personally abused, sexually, physically or via severe emotional abuse, we are required by law to report this information to the appropriate social service and/or legal authorities.

3) Court Orders

We are required to release records of clients when a court order has been placed demanding such action. Should our time be required for legal matters, depositions or any other matter that we are allowed to bill for, we will review our hourly fee and travel fee which you will be responsible for. For any legal matters, a retainer is required in advance.

Minors/Guardianship

Parents/legal guardians of non-emancipated minor clients, namely, persons under 18 years of age, have the right to access all client records of their child. Services shall only be rendered to a minor with the written consent of his/her parent/guardian. Should the client be under the full or shared custody of another individual, we require legal documentation in the form of a court order custody agreement. It is the non-minor client or parent/guardian's responsibility to share this with CW.

Couples, Group, and Family Therapy

When couples, groups, or families are receiving services, separate files are kept for each individual's confidential information and it is not shared with the other party without consent.

Benefits and Risks

Engaging in therapy does not guarantee any results but may allow you to relieve pain, learn coping skills to better deal with symptoms, enhance life and/or relationships, and other practical and psychological benefits. Some risks are also present including, but not limited to, emotional reactions, strong feelings, agitation of symptoms and inner pain. You can discuss this with the therapist to weigh risks versus benefits.

Research

As clinicians, we only practice within the scope of our training and competency. As part of our licensing, we stay as up to date as we can and work to only use evidence-based and research backed interventions. You will never be asked to engage in any experimental therapy processes without full disclosure and agreement from the onset.

Other Health Care Professions/Consultations

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Information about clients may be disclosed in consultations with other professionals or a supervisor in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, to the best of our judgement, is not disclosed.

Recording Policy

It is prohibited to record sessions, in person or via telehealth or phone in any form by anyone, including staff and the client. CW reserves the right to use video/surveillance equipment in the office for safety purposes only.

Request of Records

We are required to maintain complete treatment records. Clients are entitled to receive a copy of these records, unless we believe the information could be emotionally injurious. In such cases, we will gladly prepare a written summary of the entire record, and/or forward a copy of the record to a licensed mental health professional of your choice. Requests must be submitted in writing and may require a phone discussion to confirm. Fees may apply. Please allow 14 business days for processing.

Fees:

Our usual fee for individual psychotherapy varied by the provider and will be clearly disclosed before the therapy process begins. Sessions are generally between 45 to 60 minutes, depending on insurance or our agreement. Medication management, when offered, has other fees and lengths of sessions. You are expected to pay for each session at the time of service, unless we agreed otherwise in writing. For unusual financial hardship, we may negotiate a fee adjustment or payment plan. Fees for assessments or other specialized services are established on an individual basis. Paperwork is billed at an hourly rate as well as any legally allowed fees for phone time or depositions. Clear financial records will be maintained and will be made available within 30 days of your written request. A cancelled or bounced (bad check) check fee is $50 per incident. If you are sent to collections after due notice, fees and interest may apply, when allowed by law. There can be only one designated payer for each individual or family, couple and/or child case, who will be solely responsible for the fee.

Insurance Companies

Insurance companies and other third-party payers are given information that they request regarding services to clients if you have authorized them to be billed. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. You are responsible for all copays and bills presented. Any payments sent to you directly earmarked for CW must be handed over to us within 3 business days. **Any claims rejected by insurance, for any reason, are your financial responsibility to pay, when allowed.**

Medication Management

We may, pending staffing and availability, offer access to a psychiatrist and/or psychiatric nurse practitioner (“medical staff”) that can prescribe medication. To make use of these services, you must comply with all program requirements. This includes actively working with a therapist for an intake and ongoing therapy. If you are not in compliance with therapy goals, and you have missed a therapy session, you are required to make this up before being seen for medication management. You must inform the medical staff if you receive or received other medication(s) elsewhere as they may impact treatment. Medication should be taken as prescribed. Changing dosage without medical consult can be dangerous to your health and may result in hospitalization or death. Sharing medication is illegal.

If you have any concerns about what is being prescribed or have any unusual side effects, you must speak with the medical staff. Should you experience an emergency, dial 911 and go to the nearest emergency room. Please be sure to arrive promptly for your medication management sessions as they are difficult to reschedule given the demanding schedule of our medical staff.

You are responsible for the safe storage of your medication(s) and they should be kept away from children, pets, storage site or anywhere that they may be damaged or used incorrectly. Controlled substances should be locked up properly.

CW will not provide supplemental refills for lost or stolen medicines or prescriptions and does not accept police reports as a reason to make an exception to this policy. Should your medication be lost or stolen, you have the option to go to a local emergency room to request refills until your next appointment. Repeat loss or theft of medication may result in being discharged from our services.

Emergencies

We will always endeavor to respond promptly to your phone calls. Should you have an emergency please call 911 or go to the nearest hospital. Please get in touch with CW as soon as possible. Our office can be reached at 443-420-7379 and our clinical director, Dr. Joseph Tropper may be reached at 443-929-1801. We do not accept calls from Friday sundown until Saturday night, on Jewish religious holidays, Maryland State holidays or after our normal business days and hours. Email and text messages are not acceptable methods for contacting our office for any urgent matter. For medication management questions, when offered, you will be scheduled for the next available appointment.

No Show/Last Minute Cancellation

Except for unusual circumstances, or where prohibited by law, a full session fee (either the agreed fee, or whatever insurance would normally allow as the full amount paid for the session) will be charged for no shows or cancellations with less than 48 hours notice. To cancel or reschedule an appointment simply call the office or number the therapist provides and leave a message or email our office as soon as possible.

Termination

Professional ethics mandate that treatment shall continue only if it is reasonably clear the client is receiving benefit. If, at any time during the course of your treatment, we determine that progress is not being made, we will discuss this with the client and may terminate treatment and explain why this is necessary. The client has the right to stop treatment at any time. Should the therapist have a need to terminate or interrupt services, the client will be notified as promptly as possible and a transfer, referral or continuation of care will be arranged in line with the client's needs or preferences. If the client chooses to terminate, referrals to other therapists based on needs or preferences will be offered and the client will be offered a final 'termination' session that is recommended but not mandatory. Any client who is absent for 2 weeks, without communication with CW, may be discharged, and lose their slot without notice. We will offer you a referral upon your request if you cannot be worked back into our schedule.

Minor Supervision

Children, who are not clients, should not be brought to the office. Children under 18 must be supervised by an adult at all times, CW assumes no responsibility for their wellbeing or safety. Any violation of this rule may result in termination.

Loitering Policy:

To protect your privacy and the privacy of other clients, please do not arrive more than 10 minutes early for your appointment and please do not stay longer than 10 minutes after the completion of your appointment. We appreciate you refraining from bringing other non-clients to the office, except on a limited basis. We understand that occasionally you may have scheduling conflicts and need to wait for a ride or may arrive early, this is reasonable on a once in a while basis, subject to our discretion, but not more than once every few weeks. Non-compliance may result in discharge.

Respectful Conduct

Respectful conduct, dress, speech and behavior are expected from each client and anyone who enters our office, at all times. Any violation of this, at CW's discretion, will result in termination of services.

Telephone and Text Messaging:

In the event that CW staff must contact you for purposes such as scheduling, cancellations, billing or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please inform us of your confidential phone number or let us know about any concerns. Any clinical issues or scheduling must be discussed via phone or in person. Text messaging will not be responded to, please call and leave a message.

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Use of Internet, Email, Voice or Video Contact

If you agree to email, text or phone reminders, or submit information to us via our website, email or any form, you understand that this may not be a secure method of communication and that there is a possibility that an account can be compromised. If you chose to email us private information, we cannot guarantee confidentiality. The same goes for any non-HIPAA compliant phone, email, internet or video interactions, your participation and use of these services is considered acceptance and acknowledgement of the risks.

Group Therapy

If you attend group therapy at our practice, you give your word that you will not breach confidentiality of the other clients present and you understand that CW cannot take responsibility or be held liable for maintaining confidentiality except as relates to CW staff.

Weather Cancelation

In the event of inclement weather or other natural impediments, your safety comes first. We ask that you please notify us immediately (4 hours in advance minimum) if you're unable to attend a session, without penalty. We encourage you to get in touch with your therapist should you wish to verify our open status. Should we be closed we will make our best efforts to notify you via any contact information that we have for you. It is important that you keep your information updated.

COVID-19

Any in person services must be proceeded by the signing and abiding to our official COVID-19 waiver. If you have COVID or any other contagious illness, or any such exposure, in person sessions are not allowed.

Emergency contact

It is optional to provide us with this information. If you do so, you hereby grant us permission to contact the number/person below in any circumstance that we deem an emergency.

Payment Arrangement:

I understand that it is my responsibility to inform the company regarding any changes in my insurance, coverage or demographics. I grant permission for CW staff to contact my insurance provider to determine my benefits and to bill me for all services rendered. I understand that anything not covered by my insurance, including, but not limited to required copays, deductibles, rejected claims or use of service without an authorization in place, will be billed directly to me. I agree to pay all fees, copays or deductibles at the time of service and I understand that all such fees are my responsibility.

Use of Artificial Intelligence Program(s) in Documentation

With your written and verbal permission, I may utilize HIPAA-compliant Artificial Intelligence tools, such as Fathom, to assist with session notes, summaries, follow up assignments and treatment plans. These tools are designed to enhance accuracy and efficiency while maintaining strict confidentiality and security in compliance with HIPAA regulations. No identifiable personal information will be saved outside of my Electronic HIPAA compliant medical record software or shared outside of this secure system. By signing below, you consent to the use of AI-assisted documentation in your treatment. If you have any concerns or wish to opt out, please let me know right away and I will document not to use these tools.

Informed Consent for Teletherapy

If utilizing teletherapy, the following applies: Our goal is to help ensure this means of service is both comfortable and effective for you. Please contact CW if you have any questions or need assistance.

In addition to the usual and customary protocol of informed consent between counselor and client for face-to-face counseling, the following issues, unique to the use of distance counseling, technology, and/or social media, are addressed in the informed consent process.

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1. I understand that my health care provider wishes me to engage in a telehealth consultation/therapy and has disclosed his/her credentials, office address and contact information.

2. I understand that Telehealth is NOT an emergency service and in the event of an emergency, I will call 911 or go to the nearest hospital. I understand that response time for appropriate professional questions is 2 business days.

3. My mental health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not necessarily be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my mental health provider.

4. I understand there are potential risks to this technology, including interruptions, technology failures, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. Should an interruption occur, an alternate HIPAA compliant platform will be attempted and if that fails then, if allowed by state law, a phone contact will be attempted. I will ensure to keep my contact information updated with the therapist.

5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the session other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth room: and or (3) terminate the session at any time, by the choice of either client or therapist.

6. I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telehealth consultation.

7. I understand that billing will occur from my practitioner and I am responsible for all fees, copays, deductibles and bills.

8. I understand that my therapist is practicing in the state of **Maryland, NY, NJ or FL** or any other state they have disclosed licensure with all appointments scheduled in **Eastern Standard Time**.

9. I understand that some cultural and/or language differences that may affect delivery of services as well as the possible denial of insurance benefits and that I can choose to terminate this service at any time. Any services provided before terminated will be my financial responsibly.

10. I understand the therapist's social media policy which includes the prohibition of posting or interacting with clients outside of the office HIPAA protected space.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions and received satisfying answers.
Optional: Emergency Contact (Name, phone, email, relation)

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Mandatory to receive services:

My signature below indicates I have read the information in this document and agree to all terms and conditions. I understand their meaning and implications and how they henceforth define our professional relationship. I have been given time to have any questions answered.

Print Name: **Signature:** **Date:**