Novus Behavioral Health
556 Fire Station Road, Suite A
Clarksville, Tennessee, US - 37043-4071

--Policies, Notifications and Agreements (Required)

Patient: *

Patient Representative (if different from patient):

Consent to Evaluate/Treat & Policies Regarding Treatment/Prescribing:

I voluntarily consent that I will participate in a mental health evaluation and/or treatment by Novus Behavioral Health. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).

Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Clients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings, and sensations such as guilt, anxiety, anger, or sadness, especially in its initial phases. It is not uncommon for these feelings to have an impact on current relationships you may have. If this occurs, it is very important to address these issues in session. Usually these unpleasant sensations are short lived. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

The evaluation and treatment will be conducted by Novus Behavioral Health. I understand that the treating providers at Novus Behavioral Health are Nationally Certified Advanced Practice Providers who collaborate with Barbara Wise, MD - a board certified psychiatrist.

Disability evaluations are not provided by Novus Behavioral Health. Documentation supporting disability can be provided when requested.
(This does not include FMLA and / or Short Term Disability Benefits)

This consent is knowingly and freely given. This consent will expire 7 years after my last encounter visit at Novus Behavioral Health.

PATIENT SIGNATURE *

Special note regarding use of benzodiazepines, stimulants and other controlled substances.

Prescribing of benzodiazepines (Xanax, Ativan, Valium, Klonipin, temazepam & others) is restricted to the two following scenarios:

1. Crisis management - this is an unexpected acute life stressor such as divorce, financial loss, relocation or death of a loved one (including pets). Treatment is limited to 3-5 days. Five day extensions of treatment will be considered on a case by case basis.

2. Treatment for long term use of benzodiazepines. In this situation, a patient has been treated with benzodiazepines long term by another provider. Our treatment plan will focus on discontinuation of this medication and will take place over a period of 3 months. A minimum of two times per month counseling is required by an outside therapist. Monthly appointment are required until the taper is completed. Extensions beyond 3 months is considered on a case by case basis.

*****Under no circumstances will a benzodiazipine (Ativan, Klonipin) or hypnotic (Ambien, Lunesta) AND a stimulant (such as Adderall, Ritalin, etc.) be prescribed together. This is known to be a dangerous combination. You will need to seek the services of another provider if you are not receptive to a different treatment approach.******

***All controlled substance prescriptions requires the patient to sign & abide by a controlled substances contract per Tennessee guidelines.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Novus Behavioral Health 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 540 Heritage Pointe Dr, Clarksville, TN 37042. You can also pick up a copy in the office.

With this consent, Novus Behavioral Health may communicate to me in reference to any items that assist the practice in carrying out TPO, such as, but not limited to, appointment reminders, billing statements, insurance issues and any messages pertaining to my clinical care, including laboratory test results, among others by use of phone calls to my home, mobile or other alternative location and speak or leave a message; postal delivery and/or by the patient portal.

I hereby give my consent for Novus Behavioral Health and their Business Associates (such as, but not limited to, medical billing company, EHR vendor, collection agency, automated appointment reminder vendor, dictation service, Prescription Drug Monitoring Program database, and electronic prescription vendor) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). I can ask for a copy of the Notice of Privacy Practices provided by Novus Behavioral Health which describes such uses and disclosure in detail.

It is further understood that all information given by the patient or family member to a treating clinician is confidential and will not be released, except under special circumstances, without patient consent or consent of legal guardian as described in details in the Notice of Privacy Practices. You can authorize us to release information relating to your treatment to another person, provider or company by signing a Release of Information (ROI) form provided by the office.

By signing this form, I am consenting to allow Novus Behavioral Health to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Novus Behavioral Health may decline to provide treatment to me. I understand and agree with all the preceding information unless otherwise indicated in writing. I agree and accept the terms of all these documents. Copies of these documents are available at your request in the office.

We DO NOT provide Medical Cannabis Certification

Patient / Representative Initials: *

Financial Policy Agreement and Appointment Adherence Agreement

1. All patients are required to pay co pay, co insurance or self pay visit charge in full for the service rendered at the time of the appointment

2. Cancellation policy: There is a $75 charge for no show or cancellation with less than 24 hours notice. Reminder messages are offered as courtesy.

3. Novus Behavioral Health has the right to discharge clients at any time. However, patients who miss 2 or more appointments without 24 hour notification, or are 15 minutes or more late more than twice for their scheduled appointments, will be discharged automatically and mailed a written letter of the notification.

4. Questions: You are encouraged to call our office if there are any questions about this information. If at any time during the treatment of the patient and financial problems arise, you are encouraged to speak with our office.

5. Payment for services rendered may be made by cash, check, or credit/debit card.

By initialing below, you acknowledge that you have read, understood, and agreed with the above policies and information.

Patient / Representative Initials: *

Credit Card Consent & Policy

I authorize Novus Behavioral Health to keep my signature on file and to charge my credit/debit card account as indicated below.

A charge to the credit/debit card will ONLY be made under the following circumstances:

1. Scheduled appointments - copay, coinsurance & self pay

2. Missed appointments, chart request, medication refills when last appointment was missed or cancelled & same day refill requests.

Billing Policy Financial Policy:

Co –insurance, copay and/or deductible payment is due at time of service by cash, check, money order, Visa, MasterCard, Discover, or American Express.

Depending on the level of service provided there may be an additional fee that is patient responsibility to pay within 30 days of receipt of your statement.

Patients are responsible for their co-payments and/or deductibles at the time services are rendered for patients on Preferred Provider Plans (PPO's) or Health Maintenance Organizations (HMO's).

Any balance on an account that is greater than 30 days old is considered past due. It must be paid prior to your next visit.

A statement will be sent to your patient portal on a monthly basis and will reflect the current balance for all services rendered prior to the date on the statement. Payment is due upon receipt of statement.

Insurance:

Novus Behavioral Health
556 Fire Station Road, Suite A
Clarksville, Tennessee, US - 37043-4071

Your insurance policy is a contract between you and your insurance provider. Our billing professionals will do everything possible to help patients in communicating and negotiating with your insurance plan. We must inform patients that any difficulty regarding coverage, benefits, or payment for services provided is ultimately up to you as the patient. We are not able to guarantee your insurance company will pay for services rendered. *

☐ Yes. I understand & agree to accept responsibility for payment if my insurance company does not reimburse Novus Behavioral Health.

☐ No. I don't agree to this. I will call & discuss this with my insurance company to get confirmation that services will be reimbursed.

Please agree to bring all insurance information & proper identification to your appointment. Thank you

☐ Yes ☐ No

Our in network status with insurance payers is an ever changing circumstance. Our status of being "in network" or "out of network" will be clarified prior to your visit. You are encouraged to call your insurance and verify our status prior to your appointment.

Your insurance policy is a contract between you and your insurance company. While our billing professionals will do all they can to help our patients in communicating and negotiating with you insurance plan, we must inform patients that have any questions regarding coverage, benefits, or payment for services provided, is their responsibility to resolve.

In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered. If payment from your insurance carrier is not received within forty-five (45) days, we will seek full payment from you. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information will become your responsibility after thirty (30) days.

Novus Behavioral Health and its employees do not guarantee that payment will be authorized for medical services; therefore, this office is not responsible for any adverse payment decisions or misuse of information.

Notification of any change in your insurance status (i.e. new company, deductible, co-pay amounts) must be provided to the office forty-eight (48) hours in advance of next visit, or payment in full will be required.

Miscellaneous Charges:

Fees for medical records are $25.00 for the first 20 pages, and $.50 for each page thereafter and may take up to 15 business days to obtain. Report preparation fees are based on the time involved.

Any returned checks are subject to a $30 service fee. Any returned check must be resolved before any future appointments can be arranged.

Novus Behavioral Health contracts with an outside collection agency to collect delinquent accounts. Once an account is placed with the collection agency the patient must deal directly with the agency for payment of the account. In the event of account placement with collection agency the applicable collection fees will be added to that account. Currently, these additional fees are equal to 30%-50% of the total balance owed.

If you miss your appointment or do not cancel your appointment 24 hours in advance, our policy is to charge the full rate and is payable prior to future visits. These will not be billed to your insurance company. Please help us to serve you better by keeping your scheduled appointments or canceling in advance.

Clinical self pay charges will be as follows: (Medicare Minimum Required)

1. Initial Psychiatric Evaluation $195

2. Follow-Up Visits $145

3. Follow up med check (refill only / no adjustments needed) $75

I understand that this form will be valid for the duration of my treatment with this office UNLESS I cancel through written notice to Novus Behavioral Health.

By initialing below, you acknowledge that you have read, understood, and agree with the above policies.

Patient / Representative Initials: *

Patient Rights and Responsibilities

As a patient at Novus Behavioral Health, you have the following rights:

1) The Right to Privacy and Confidentiality: All records and communication regarding your health information will be kept secure and be kept confidential in compliance with state and federal laws. Under state and federal laws, there may times when confidentiality may have to be broken and health information disclosed to certain parties. This includes cases of those who pose a danger to themselves or others, domestic violence, suspected abuse or neglect. I may also be mandated to report your health information by court order, or when it is necessary to prevent or lessen a serious imminent threat to the health or safety of a person or public.

2) The Right to Medical Records: You may request a copy of your medical records pertaining to your treatment.

3) The Right to Account Information: You may request an accounting of certain disclosures that I make of your health information. A reasonable fee may be applied.

4) The Right to Clear Instructions and Up-to-date Information: I will make it a priority to clearly explain you or your child's diagnosis, discuss prognosis, discuss treatment options, discuss the of risks and benefits of treatment(s), discuss the nature and purpose of certain tests and procedures, prescribe therapy or medications, order laboratory tests, provide the need for follow-up visits, recommend other mental health or medical professionals as referrals, and discuss any additional measures to achieve desired outcomes for you or your child's diagnoses.

5) The Right to Accept or Refuse Treatment Recommendations: my participation in your care is based on the knowledge acquired through education and experience. You may disagree with my recommendation(s) at any time as determined through the knowledge acquired through your education and experiences. Ultimately, it is your treatment plan. You will decide what recommendations work best for you.

6) The Right to Seek Additional Professional Opinions

7) The Right to a Safe Environment

8) The Right to Professionalism and Courtesy

As a patient, you have the following responsibilities:

1) Contact your treatment provider for any serious situation that arises, even after normal office hours

2) Provide correct, and complete information about your health

3) Follow the agreed upon treatment plan to achieve your treatment goals

4) Advise your treatment provider of any changes in your health condition

5) Be respectful the rights of other patients and building/office personnel

6) Arrive for your scheduled appointment on time and call the office if you are unable to make your appointment

7) Meet the financial obligations for your care at the time care is rendered.

By initialing below, you acknowledge that you have read, understood, and agree with the above policies.

Patient / Representative Initials: *

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. “PHI” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission. HealthcareOperations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities,

employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations w without your authorizations.These situations include: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates.Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500. Other Permitted and Required Uses and Disclosures will be made only with your consent. Authorization or Opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.Your Rights: You have the right to inspect and copy your PHI, under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request; even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your PHI, if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we've made, if any of your PHI we reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (931) 820-0242.

Clinic Communication Policy: Messages, Appointments & Medication Refills

1. Novus Behavioral Health is a portal based clinic. This means most communication will happen via your portal account. Portal access can be found at the bottom right hand corner of the website. After logging into the portal you can click on the section labeled: "Useful Information" - there are multiple video tutorials about using your portal account.

2. Once your portal account has been established no further emails will be accepted. Email is not a secure method of communication & violates HIPAA privacy practices.

3. We do not receive text messages.

4. General messages will be responded to within 24 hours.

5. Please allow 48 hours to process refill requests.

6. One same day refill request will be allowed per year. Any additional same day refill requests will result in a $25 charge.

7. More than two occurrences of early refill requests for controlled substances will result in discharge from the clinic.

8. If you are unable to access your portal account, please call the office.

9. If you are unable to utilize portal. Please call the office with your message or requests. The receptionist will send a message on your behalf.

10. After your first appointment, all further appointments should be scheduled through your portal account.

Patient / Representative Full Signature *

Date: *