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Terms of Services

TeleHealth Services

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Telehealth services also include remote monitoring, tele pharmacy, prescription re-fills, and appointment scheduling.

The Hope Wellness Center providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any combination of the following: (1) patient medical records; (2) medical images; (3) live two-way audio and video; (4) interactive audio; (5) storage and forwarding of electronic communications; and (6) outputting data from medical devices, and sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data. Electronic systems used will also include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
Responsibility for your medical care should remain with your local primary care doctor, if you have one, as does your medical record.

Expected Benefits:
· Improved access to medical care by enabling you to remain in your local healthcare site (e.g., home) while the provider consults and obtains test results at distant/other sites.
· More efficient medical evaluation and management.
· Obtaining the expertise of a specialist.

Possible Risks:
· Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.
· In rare events, the provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your provider.
· In rare events, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgment errors.
· In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this document, you acknowledge that you understand and agree with the following:

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1. I hereby consent to receiving The Hope Wellness Center's services via telehealth technologies. I also understand it is up to the The Hope Wellness Center provider to determine whether my needs are appropriate for telehealth.

2. I have been given an opportunity to select a consulting provider from The Hope Wellness Center prior to the consult, including a review of the consulting provider's credentials.

3. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that The Hope Wellness Center will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be in other areas, including out of state.

4. I understand there is a risk of technical failures during the telehealth encounter beyond the control of The Hope Wellness Center. I agree to hold harmless The Hope Wellness Center for delays in evaluation or for information lost due to such technical failures.

5. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care. I understand that I may suspend or terminate access to the service at any time for any reason or for no reason. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that the The Hope Wellness Center health service specialists are not able to connect me directly to any local emergency services.

6. I understand the alternatives to telehealth consultation, such as in-person services, that are available to me. In choosing to participate in a telehealth consultation, I understand that some parts of the services involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the The Hope Wellness Center consulting healthcare provider (e.g., labs or bloodwork).

7. I understand that recording any member of The Hope Wellness Center without their consent is expressly prohibited.

8. I understand that although I may expect the anticipated benefits from the use of telehealth in my care, no results can be guaranteed.

9. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Persons may be present during the consultation other than the The Hope Wellness Center provider to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.

10. I understand that any Drug Enforcement Agency controlled substances are prescribed at the sole discretion of the provider in compliance with federal and state regulations. There is no guarantee that I will be given a prescription at all. The Hope Wellness Center may require an in-person visit from time to time to continue to prescribe medications.

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11. I understand that if I participate in a consultation, I have the right to request a copy of my medical records, which will be provided to me at a reasonable cost for preparation and shipping.

12. I understand that in the event of any problem with the website or related services, I agree that my sole remedy is to cease using the website or terminate access to the service. Under no circumstances will The Hope Wellness Center or any The Hope Wellness Center subsidiary or affiliate be liable in any way for the use of the telehealth services, including but not limited to: any errors or omissions in content or infringement by any content on the website of any intellectual property rights or other rights of third parties, or for any losses or damages of any kind arising directly or indirectly out of the use of, inability to use, or the results of use of the website, and any website linked to the website, or the materials or information contained on any or all such websites.

13. I agree that I will not hold The Hope Wellness Center, its subsidiaries, or affiliates liable for any punitive, exemplary, consequential, incidental, indirect or special damages (including, without limitation: any personal injury, lost profits, business interruption, loss of programs or other data on my computer or otherwise) arising from or in connection with my use of the website whether under a theory of breach of contract, negligence, strict liability, malpractice or otherwise, even if we or they have been advised of the possibility of such damages.

14. I understand that The Hope Wellness Center makes no representation that materials on this website are appropriate or available for use in any other location. I understand that if I access these services from a location outside of the United States, that I do so at my own risk and initiative. I understand that I am ultimately responsible for compliance with any laws or regulations associated with my use.

HIPAA Information

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.
We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for The Hope Wellness Center (further referred to as the “Practice”) and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The Practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents, which may include PHI, by government agencies or insurance payers in the normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager, provider, and/or therapist.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the Practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request a change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

10. You understand that as part of your healthcare, this Practice originates and maintains health records describing your health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. You understand that this information serves as:

o a basis for planning your care and treatment.
o a means of communication among the health professionals who may contribute to your health care.
o a source of information for applying your diagnosis and surgical information to my bill.
o a means by which a third-party payer can verify that services billed were provided.
o a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.
11. You understand that as part of your care and treatment it may be necessary to provide your Protected Health Information to another covered entity.

Use and Disclosure of Protected Health Information

I hereby give my consent for THE HOPE WELLNESS CENTER (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment, and health care operations (TPO).

With this consent, the Practice may call or e-mail me at my home or other alternative location and leave a message by voice, e-mail, or in-person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and anything pertaining to my clinical care, including laboratory test results.

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With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements, and anything pertaining to my clinical care if they are marked “Personal and Confidential.”

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Cancellation, No-Call/No-Show, and Refund Policy

The Hope Wellness Center desires to be your partner in excellent overall health and wellness. Missed appointments may have a direct impact on your mental health. As part of our effort to ensure quality mental health services, we require 24 hours’ notice if you are unable to make your appointment so that we can reschedule you as soon as possible.

Please carefully read and take note of our Missed Appointment/Cancellation Policy:

1. If you are a no-call/no-show or cancel with less than 24 hours' notice to a scheduled appointment, you will incur a $50.00 cancellation/missed appointment charge.

2. Three missed or no-call/no-show appointments within a 90-day period will result in your discharge from service at the discretion of the provider.

3. It will be considered a cancellation if you attend a telehealth session and are unable to maintain the session (due to your request to end earlier than is allowable for billing purposes and/or due to non-adherence of our Location Agreement).

Please carefully read and take note of our Refund Policy:

1. Your satisfaction is 100% guaranteed or your money back!
2. If you are unsatisfied with the service provided to you, we want to find a way to make it right or give you your money back.

At The Hope Wellness Center, we want you to succeed in achieving your goals of improved health and wellness. Active engagement, investment in your treatment, and consistent attendance are necessary for therapy to be effective. **Should you be discharged for an attendance concern and wish to re-engage in therapy, you will be placed back on a placement list**.

Electronic Communication Consent and Authorization

With respect to any services provided or that are planned to be provided, I, the undersigned, fully consent to and authorize The Hope Wellness Center or any of its automated systems to contact me via phone (including my cellular phone by way of phone call or text message) in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items, medication, or appointment reminders).

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I hereby agree and consent to enter into and sign agreements with The Hope Wellness Center electronically, and to receive notices, notifications, and communications from The Hope Wellness Center electronically, as set forth more fully herein.

Regarding Electronic Agreements and Signatures:

· The Hope Wellness Center and I can enter into and sign agreements electronically, including, but not limited to consent forms, clinical assessments, disclosures, authorizations, financial agreements, and amendments to agreements (collectively "Agreements").

· I agree my electronic signature is the legal equivalent of my manual signature on any Agreement. By signing any Agreement electronically, I consent to be legally bound by the Agreement's terms or disclosures. My use of a keypad, mouse, or other device to sign or to select an item, button, icon, or similar action regarding any Agreements constitutes my signature (my "E- Signature") in acceptance and agreement the same as if signed in person.

· I agree that no certification authority or other third-party verification is necessary to validate my E-Signature and that the lack of such certification or third-party verification will not in any way affect the enforceability of the E- Signature or any resulting contract between myself and The Hope Wellness Center.

· The parties' electronic signatures shall be valid and enforceable in accordance with the Electronic Signatures in Global and National Commerce Act ("E- SIGN"), 15 S.C. 7001, et seq.

· All Agreements shall constitute original documents admissible in a court of law when printed from electronic files and records established and maintained by either party in the normal course of business.

Regarding Electronic Delivery of Communications:

I agree to receive electronically all communications, documents, notices, and disclosures (collectively, "Communications") that The Hope Wellness Center provides in connection with my treatment.

Communications include:
o Administrative Information, such as scheduling notices.
o Clinical messages or other updates from Provider.
o Medical messages or other updates from Provider.
o Financial messages including receipts, invoices, or fees.
o Federal and state tax statements The Hope Wellness Center is required to make available to me. o Any other messaging or notices.

How I Can Withdraw Consent:

I understand I may withdraw my consent of E- Signature and/or to receive electronic Communications by sending my withdrawal of consent to The Hope Wellness Center. If I fail to provide or if I withdraw my consent to receive Communications electronically, The Hope Wellness Center reserves the right

to require that treatment occur in person, to ensure proper compliance with all required signature processes.

Requesting Paper Copies of Electronic Communications:

If, after I consent to receive Communications electronically, I would like a paper copy of a Communication The Hope Wellness Center previously sent, I may request a copy within 180 days of the date The Hope Wellness Center provided the Communication to me by contacting The Hope Wellness Center. The Hope Wellness Center will send the paper copy to me by U.S. mail. For The Hope Wellness Center to send me paper copies, I must have a current street address on file as my "Home" address in my The Hope Wellness Center record. If I request paper copies, I understand and agree that The Hope Wellness Center may charge a Records Request Fee for each Communication.

Updating my Contact Information:

It is my responsibility to keep my primary e-mail address up to date so that The Hope Wellness Center can communicate with me electronically. I understand and agree that if The Hope Wellness Center sends me an Electronic Communication, but I do not receive it because my primary e-mail address on file is incorrect, out of date, blocked by my service provider, or I am otherwise unable to receive Electronic Communications, The Hope Wellness Center will still be deemed to have provided the Communication to me.

I understand that if I use a spam filter that blocks or re-routes e-mails from senders not listed in my e-mail address book, I must add The Hope Wellness Center to my e-mail address book so that I will be able to receive the Communications The Hope Wellness Center sends to me.

I can update my primary e-mail address or street address at any time by contacting The Hope Wellness Center. If my e-mail address becomes invalid such that Electronic Communications sent to me by The Hope Wellness Center are returned, The Hope Wellness Center may require that services be suspended until The Hope Wellness Center receives a valid, working primary e-mail address from me.

Hardware and Software Requirements:

To receive electronic communications, I understand I must have a computer, tablet, smartphone, or similar device that can access the Internet and my e-mail account and address where The Hope Wellness Center may communicate with me via e-mail. My signature of this Consent electronically demonstrates my ability to access Communications and other information electronically.

Location and Privacy Agreement

I acknowledge that, at the time of my session, I must be located in the state where I have chosen to seek the licensed services of The Hope Wellness Center. I agree that I will be at the same address each session. If for some reason I am not at the same address (home address), I agree to notify my treatment team of the address I am at before services begin. I acknowledge that I must participate from a stationary location. I may not operate a vehicle during sessions, be in a moving vehicle while in session, nor walk around with an electronic device while in session. I must attend services in a

confidential space that is free from distractions. No other individuals in my household should be in the same space or hear the discussions that are being had virtually. Ongoing privacy issues will result in the need to end session and/or removal from group, which will be considered an absence.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you, in the past and present. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance. Additionally, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included. It is important that you disclose these to your provider.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

CHILDREN POLICY

Due to the sensitive nature of Mental Health and Substance Use Disorder services as well as safety concerns, clients with children (under the age of 18) must make alternative arrangements for childcare during visits to our offices. This policy is based on the following reasons:

· A lack of personnel to safely care for children while clients are undergoing procedures or consultations.
· Caring for a child can distract a client from understanding the information and instructions given at a visit.

If you arrive for an in person or virtual appointment with a child or children, you will be asked to reschedule your appointment for a date in which you are able to obtain childcare.

Financial Agreement

Thank you for choosing The Hope Wellness Center as your health provider. We believe that good care for you and your family starts with good communication and we have created this policy to help our patients understand their financial responsibilities. If at any time you have questions, please ask us. Please sign below after reading this policy. A copy will be provided to you upon request.

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The following constitutes the financial policy of The Hope Wellness Center, hereinafter "Facility", with respect to services rendered at this facility.

1. Facility is contracted with several commercial insurance plans. All fees are based upon your insurance benefits. If you are not covered under an insurance plan that we are contracted with, fees are according to the self-pay rates.

2. Facility will bill insurance carriers on behalf of the patient where applicable. This is a service that we provide for our patients. The patient is still responsible for all charges incurred.

3. Facility has contractual agreements with many insurance carriers. Some contracts require that we accept payment from the insurance carrier as payment in full. In such cases, patients may not be responsible for copayments, coinsurances, and deductibles. Copays and other fees are due at the time of your visit.

4. Your insurance company may not reimburse us for medical services or only make partial payment, because of the following:

◦ Deductible has not been met for the current calendar year.
◦ Co-insurance may be applied to the charges.
◦ Service may not be deemed as a payable benefit for your plan.
◦ Policy has terminated, or there is a gap in coverage.

5. All billing inquiries will be handled by the The Hope Wellness Center billing department, which can be reached by calling the direct number 401-324-9100. Messages left on our voicemail can take up to 3 business days to address.

6. The Hope Wellness Center requires all TeleHealth patients to put credit card information on file. Our merchant services follow strict data retention rules as required by the merchant processing system. No card information is visible to staff once the card is placed on file. The merchant company utilizes multiple security measures to protect your data, including tokenization. Our staff will process copay and other fees associated with your visit after you visit occurs. In the event you do not attend your appointment, your card can be charged the cancellation/no show fee per policy.

7. Our office requires 24 hours' notice to change or cancel a scheduled appointment. If you do not provide the required 24-hour notice, a fee will be charged. See our Cancellation Policy Consent form for details.

◦ If you cancel less than 24 hours' notice or no show 2 appointments in a row, you will be discharged per provider discretion.
◦ Your provider will reach out 3 times prior to discharging you from our office.
◦ If you are more than 15 minutes late for your scheduled appointment time, you will need to reschedule the appointment and will be charged the missed appointment fee.

8. After we bill your insurance for services rendered and apply payments that were collected, including any remaining balances that your insurance has adjusted to patient responsibility, you will receive a statement. Statements go out every 30 days during our billing cycles. Any balances that are

not paid in full prior to the following billing cycle will incur a fee. You will have that 30-day period to discuss any fees and make payments through the patient portal, mail, over the phone, or in-person.

9. I understand that my records are protected under Federal Confidentiality regulations (Federal laws 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 and Federal regulations 42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS), and/or related conditions.

I hereby assign and convey directly to Facility, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Facility, regardless of its managed care network participation status.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF ANY APPLICABLE INSURANCE OR BENEFIT PAYMENTS.

I hereby authorize Facility to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Facility all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Facility or its attorneys to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement as described above, I also assign and/or convey to Facility any legal or administrative claim or cause of action arising under any group health plan, employee benefits plan, health insurance/tort fees/insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the facility. This includes any right to pursue those legal or administrative claims or cause of action. This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representation to convey to Facility all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by facility, including rights to any settlement, insurance or applicable legal or administrative remedies. This includes damages arising from ERISA breach of fiduciary duty claims. Facility is given the right by me to (a) obtain information regarding the claim to the same extent as me; (b) submit evidence; (c) make statements about facts or law; (d) make any request including providing or receiving notice of appeal proceedings; and (e) participate in any administrative and judicial actions and pursue claims or causes of action or rights against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Facility (The Hope Wellness Center), as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, the assignment set forth herein is valid for all administrative and judicial reviews under all applicable federal and state law. A photocopy of this assignment is to be considered valid, the same as if it were the original.

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Informed Consent for Assessment and Treatment

Treatment

• The Hope Wellness Center performs an initial assessment to evaluate individual need and program suitability, and to facilitate placement with The Hope Wellness Center treatment provider(s) for services.
• There may be a period between assessment and placement. During that time, the individual understands they are not receiving treatment from The Hope Wellness Center.
• Once the patient begins treatment with The Hope Wellness Center providers, the patient voluntarily participates in ongoing mental health treatment services which may include therapy, physical examination, diagnostic tests, and medical recommendations. Management of mental health services may also be included, such as medication, and other interventions as indicated by medical history, physical examination, and laboratory parameters.
• A variety of techniques and interventions may be utilized in the course of services. It is the patient's responsibility to participate in the treatment planning process, in conjunction with The Hope Wellness Center providers, to identify desired goals and appropriate corresponding interventions/techniques. The Hope Wellness Center providers educate patients on the rationale, risks, and benefits of the interventions/techniques to be provided. The patient maintains the right to ask questions about their treatment throughout the course of services.

Confidentiality

• The Hope Wellness Center adheres to all Federal Laws of confidentiality and, within limits detailed below, will keep information revealed in treatment strictly confidential. No patient information, with the exceptions outlined below, will be disclosed to any other person or entity without written permission.
• The Hope Wellness Center is required by law to reveal information obtained during treatment to other persons or entities without patient permission in the following situations:
1. Threats to physically harm or kill another person: The Hope Wellness Center is required by law to inform the intended victim, appropriate law enforcement, and/or medical/psychiatric facilities. This is called a Duty to Warn.
2. Threats to physically harm or kill oneself: The Hope Wellness Center is required by law to inform appropriate law enforcement and refer the patient to the nearest emergency psychiatric screening services unit.
3. Information disclosed indicating that a child, dependent adult, or elderly person is the victim of physical, sexual, emotional abuse or neglect: The Hope Wellness Center is required by law to report such abuse/neglect to the appropriate agencies.
4. Certain court orders.

Payment

• The patient is responsible for the full cost of the services provided. The Hope Wellness Center will bill the patient's health insurer as a courtesy and will work with the patient to ensure that they receive the full benefit of applicable insurance coverage.

Emergencies

• The Hope Wellness Center does not provide emergency services. A PATIENT EXPERIENCING A MEDICAL OR PSYCHIATRIC EMERGENCY SHOULD CONTACT 911 AND/OR THE LOCAL PSYCHIATRIC SCREENING SERVICE.
• Other resources include, but are not limited to: Suicide Prevention Hotline, 1-800-273-8255; Suicide Prevention Text Services: text the Crisis Text Line at 741741; https://suicidepreventionlifeline.org/; http://www.yourlifeyourvoice.org; Mental Health Warm Line, (866) 854-8114.

Consent

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1. I give permission for The Hope Wellness Center and its associated clinicians and other personnel to give me treatment and perform all clinical services deemed necessary.
2. I consent to treatment and am aware of the consequences, risks and benefits associated. I understand that the practice of medicine and other health care professions is not an exact science and I further state that I understand no guarantee has been made or can be made as to the results of the treatments or examinations.
3. I am informed and understand that services may be rendered by an Associate Counselor under the supervision of a Professional Counselor, or a Qualified Supervisor as defined in the applicable state law in my jurisdiction.
4. I understand that clinical supervisors will periodically review and discuss my counseling sessions with my therapist, and they may provide direction about the course of my care.
5. I understand that if I fail to follow any communicable-disease-related referrals, The Hope Wellness Center will need to report such failure to the County Health Department.
6. In case of severe medical emergency, I have listed an emergency medical contact on a release form and do authorize The Hope Wellness Center to contact that party should such an emergency occur.
7. I have disclosed my health history information, including allergies, reactions to medication, diseases, and past procedures. I understand that withholding this information may affect the outcome of any procedures or courses of treatment. I understand that if I am prescribed any medication by any provider, I am expected to inform my attending clinician immediately.
8. I understand that the The Hope Wellness Center Clinical Director will have access to my treatment record. I understand that the supervisor is ultimately responsible for all aspects of my treatment.

By signing this Informed Consent for Treatment, you voluntarily agree to receive mental health assessment, care, treatment, and services, and authorize the The Hope Wellness Center provider(s) to provide such care, treatment, and services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, and services, and that you may stop such care, treatment, and services at any time.

By signing this document, I attest that I have read, understood, and agree to the terms and information contained in this document.