Clayton S. Hall, D.O. & Associates, LLC

Patient Demographics

First name: _____ Middle name: _____ Last: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Main phone: _____ Cell phone: _____

Date of birth: ____/_____/_____ Social Security Number: _____

Marital status (Circle one): Single Married Separated Divorced Widowed

Employment status (Circle one): Employed Unemployed Student Retired Disabled

Email address: _____

Who referred you to our office? _____

What is the purpose for this visit? _____

Primary Care Physician: _____ with phone number: _____

Name of your pharmacy: _____ with phone number: _____

Name of emergency contact: _____ with phone number: _____

Current medical conditions: _____

_____

Current medications that are **NOT** for mental health (please list name, dose and frequency) _____

_____

Allergies to medications? _____

Have you ever been treated for a mental health or psychiatric disorder (circle one): Yes No

If yes, please explain: _____

_____

Current psychiatric medications: _____

_____

Past psychiatric medications: _____

_____

Clayton S. Hall, D.O. & Associates, LLC
Consent &
Financial Responsibility Agreement

Today's Date: (Month/Day/Year):___/___/____

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: (Month/Day/Year) _____/_____/_____ SSN: _____

Street Address: _____

City:_____ State: _____ Zip Code: _____

By signing this consent form, I agree with the financial responsibilities outlined below by Clayton S. Hall, D.O. and Associates, LLC ("**Hall & Associates")** relevant to my evaluation and treatment by Hall & Associates.

The effective date of this agreement is _____ and will expire two years from that day. Upon expiration of this agreement, a new agreement will be necessary to continue services.

I understand that Hall & Associates does not accept any form of insurance and I accept full financial responsibility for all services furnished by Hall & Associates including my office visits.

I understand that no provider at Hall & Associates is excluded from participation in the Medicare Program, Kentucky Medicaid Program or any other insurance carrier. However, Hall & Associates has opted out of participation in these programs.

I understand that at no time can a claim be submitted to the Medicare Program, Kentucky Medicaid Program or any other insurance carrier including Medigap or other supplemental coverage policies for the services provided to me by Hall & Associates.

I understand that no payment will be made by any insurance carrier for any items or services provided to me by Hall & Associates.

I understand that this contract only applies to services provided to me by providers of Hall & Associates. All items and services provided to me by providers not with Hall & Associates who have not opted out of these programs will continue to be covered by my insurance (the Medicare Program, Kentucky Medicaid Program or any other insurance carrier including Medigap or other supplemental coverage policies) and I am under no obligation to enter into any other contract.

I understand that the charge limits for the Medicare Program, Kentucky Medicaid Program or any other insurance carrier do not apply to the services furnished by Hall & Associates.

I understand that all information will be kept confidential by all staff and providers, except in situations explained in the NOTICE of PRIVACY PRACTICES, which has been provided to me.

I understand that I may revoke this agreement at any time.

_____
Patient's Signature

_____
Date

ADVANCE BENEFICIARY NOTICE

CLAYTON S. HALL, D.O. & ASSOCIATES, LLC DOES NOT PARTICIPATE IN ANY INSURANCE PLANS INCLUDING MEDICARE AND MEDICAID

Patient Name: Identification Number:

NOTICE: Clayton S. Hall, D.O. & Associations, LLC ("**Hall & Associates**") does not accept or bill health insurance plans or programs, including Medicare or Medicaid, for any of the services that it provides to patients. If you want Hall & Associates to provide physician services to you, you must pay Hall & Associates for those services by cash, credit card or money order. Other providers may accept and bill health insurance plans or programs, including Medicare or Medicaid, for services. If you want the cost of your services to be covered by health insurance, Medicare or Medicaid, you must go to another provider that participates in these programs. Hall & Associates is not a participating provider for any of these.

COVERAGE: Medicare, Medicaid and health insurance plans may cover physician services, laboratory services and medications for substance use disorders or behavioral health conditions if you are a covered beneficiary. Laboratory and pharmacy services may not be covered when ordered for you by Hall & Associates' providers because Hall & Associates does not participate in insurance plans or programs.

WHAT YOU NEED TO DO NOW:

- Read this notice so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose below whether to receive services from Hall & Associates:

☐ **OPTION 1.** I want physician services from Hall & Associates and acknowledge that Hall & Associates is not a participating provider and will not bill my health insurance, Medicare or Medicaid for my services. Hall & Associates will ask me to pay for my services and hold me responsible for payment. **I elect to receive physician services from Hall & Associates even though I am or may be covered by other insurance including my health insurance plan, Medicare, or Medicaid.**

☐ **OPTION 2. I do not want physician services from Hall & Associates.**

This Notice is not an official document from Medicare, Medicaid, or any health insurance plan and represents Hall & Associates' commitment to inform patients of the right to choose a provider.
If you have other questions about Medicare billing, call **1-800-MEDICARE**.
If you have other questions about Medicaid billing, please contact your Medicaid Managed Care plan or the Department of Medicaid Services.

SIGNING BELOW MEANS YOU UNDERSTAND THIS NOTICE. YOU MAY KEEP A COPY.

Signature:	Date:
Print Name:	

CLINIC STAFF: Give a copy of this document to the Patient. File original in Patient's medical records.

Dr. Clayton S. Hall, D.O. & Associates, LLC
3229 Summit Square Place, Suite 200
Lexington, KY 40509
Phone: (859) 333-1477

Today's Date: _____

Patient Name: _____ DOB: _____

CURRENT PHARMACY

Pharmacy:

_____ Pharmacy

Address: _____

Pharmacy Phone Number: _____

Or REQUEST TO CHANGE PHARMACY

Requesting to change pharmacy to: _____

Address of new pharmacy: _____

Phone number of new pharmacy: _____

Name of previous pharmacy: _____

I understand if I need to have my prescription filled at another pharmacy that I will contact Dr. Hall's office to report the pharmacy filling the prescription and the reason for the change.

_____ _____
Signature Date

Clayton S. Hall, D.O. & Associates, LLC

Controlled Substances Agreement

I, _____, a patient of the office of Clayton S. Hall, D.O. & Associates, LLC ("**Hall & Associates**"), have been informed that individuals who are prescribed certain controlled substances including, but not limited to, stimulants, benzodiazepine tranquilizers, and barbiturate sedatives are at risk of developing an addictive disorder or suffering a relapse of a prior addiction and can abuse those substances or may allow abuse by others. Therefore, I have been informed and understand that it is necessary to observe strict rules pertaining to their use, and I agree to follow the terms and procedures described in this Agreement as consideration for, and as a condition of, the willingness of Hall & Associates to prescribe (or to continue prescribing) controlled substances for my treatment.

1) I will inform my physician of any current or past substance abuse, or any current or past substance abuse by myself or any member of my immediate family.

2) I agree that I may be subject to a voluntary evaluation by psychologists or psychiatrists, possibly at my own expense, before any controlled substances are prescribed to me. I agree that the need to be evaluated by psychologists or psychiatrists may be revisited every three (3) to six (6) months thereafter while taking the medication.

3) All controlled substances must come from a provider at Hall & Associates. My controlled substances will come only from Hall & Associates, unless specific written authorization is obtained from this office for an exception.

4) I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform Hall & Associates.

5) I will inform Hall & Associates of any and all current or new medications and/or medical conditions and any adverse effects I experience from any of the medications that I take.

6) I will inform my other healthcare providers that I am taking all controlled substances prescribed to me, and of the existence of the Agreement. In the event of an emergency, I will provide the foregoing information to emergency department providers.

7) I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.

8) I will not allow anyone else to have, use, sell, or otherwise have access to these medications. The sharing of medication with anyone is against the law and is absolutely forbidden under this Agreement.

9) I understand that controlled substances may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them secure and away from other people for their own safety.

10) I understand that tampering with a written prescription is a felony, and I will not change, alter, or tamper with my doctor's written prescription.

11) I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

12) I agree not to alter my medication in any way, and I will take my medication whole and as prescribed; it will not be broken, chewed, crushed, injected, or snorted.

13) I will take my medication as instructed and prescribed, and I will not exceed the maximum prescribed dose. Any change in dosage must be approved by a provider at Hall & Associates.

14) I understand that controlled medications should not be stopped abruptly as withdrawal syndromes or dangerous side effects may develop.

15) I will cooperate with unannounced urine or serum toxicology screenings as may be requested, as well as any random pill counts of medication by my prescribing provider. Failure to comply may result in immediate discharge from this practice.

16) I understand that the presence of unauthorized and/or illegal substances in the screenings described in the paragraph above may prompt discharge from treatment by Hall & Associates.

17) I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication, a copy of a filed police report or a statement from me explaining the circumstances may be required before an additional prescription is considered. If I request an early refill due to lost, damaged, or stolen prescriptions twice within a year, I may be discharged from treatment by Hall & Associates.

18) I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescription(s) may not be filled prior to the appropriate date.

19) If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtain medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances prescription and administration.

20) I will keep my scheduled appointments in order to receive medication renewals. If I need to cancel my appointment, I will do so a minimum of twenty-four (24) hours before it is scheduled.

21) I understand that I may be asked to bring my medications in their original container to Hall & Associates office while I am on controlled medication.

22) Refills generally will not be given over the phone, after office hours, during the weekends, and on holidays. I will not contact Hall & Associates between appointments, at night, or on weekends for refills.

23) I understand that any medical treatment is initially a trial, with the goal of treatment being to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine the benefits of continued therapy, and continued prescription is contingent on whether my physician believes that the medication usage benefits me. I will comply with all treatments as outlined by Hall & Associates.

24) Hall & Associates explained the risks and potential benefits of these medications including, but not limited to psychological addiction, physical dependence, withdrawal, and over dosage.

25) I understand that failure to adhere to this Agreement or failure to comply with the physician's treatment plan or treatment policies may result in cessation of treatment with controlled substances by this physician, referral for further specialty assessment, or possible discharge from treatment by Hall & Associates.

26) I, the undersigned patient, attest that the foregoing was discussed with me and that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by the Agreement.

_____	_____
Physician Signature	Patient Signature
_____	_____
Date	Date

4893-3787-2848, v. 1

Clayton S. Hall, D.O. & Associates, LLC

Medication Adherence Agreement

At Clayton S. Hall, D.O. & Associates, LLC ("**Hall & Associates**") medication adherence simply means sticking to the medication prescribed/ordered for you. Adhering to medication is also taking the medication as directed by a health care professional - whether taken in pill form, inhaled, injected, or applied topically.

Not taking medication as prescribed is called non-adherence. Many people never fill their medications, or they may never pick up their filled prescriptions from the pharmacy. Other people bring their medication home, but don't follow their health care professional's instructions - they skip doses or stop taking the medicine.

Specifically, non-adherence includes:

- Not filling a new medication or refilling an existing medication when you are supposed to.
- Stopping a medication before the instructions say you should or without first tapering off the medication to prevent dangerous results.
- Not taking medication as instructed (i.e., taking more or less of the prescribed/ordered medication, or not taking medications at the same time every day.)

Often there is no single reason someone does not take their medicine as directed, but rather a combination of reasons. One person may face different barriers at different times as he or she manages his or her condition. Whatever the reason, the result is always the same - patients miss out on life - saving benefits, a better quality of life, and lose protection against future illness or serious health complications.

All medicines have risks and benefits. When a patient works with their health care professional to decide to use medicine to help manage a long-term health condition, he or she accepts certain risks in exchange for potential health benefits. Consumers can help manage those risks by using medicines safely, including storing & disposing of them safely.

Importance of Medication Adherence Specifically at Hall & Associates:
Some of the medications prescribed at Hall & Associates are controlled substances which have an increased requirement for compliance from patients. This is very important because of the health and possible legal consequences associated.

- All patients must take medication EXACTLY as prescribed/ordered
  - Do not attempt to adjust the dose of your medication up or down without consultation with your physician or nurse practitioner.
- Keep medications in a safe and secure location.

    - Theft of medication will not result in an early refill.
- If you have any questions concerning medication, set up an appointment with the nurse practitioner/physician.
- Because of the medication you are taking and any history of substance abuse, it is vital that you coordinate your other medical appointments or surgical/dental procedures with the appointments you have with Hall & Associates. Plan ahead.
- It is important that you tell your primary care physician or any other physician who writes a prescription that you are receiving treatment services at Hall & Associates.
- **DO NOT EVER SELL YOUR MEDICATION OR TRY TO BUY MEDICATION FROM SOMEONE. THIS WILL LIKELY RESULT IN IMMEDIATE DISMISSAL FROM THE PROGRAM AND CAN RESULT IN LEGAL CONSEQUENCES FOR YOU.**
- **NON-ADHERENCE WITH YOUR MEDICATION REGIMEN CAN ALSO RESULT IN RESTRICTIONS BY YOUR INSURANCE COMPANY THAT CANNOT BE RESOLVED BY THE TEAM AT HALL & ASSOCIATES. YOU MAY LOSE THE ABILITY TO GET YOUR MEDICATIONS PAID FOR BY INSURANCE.**
- **BRING ALL MEDICATIONS PRESCRIBED BY HALL & ASSOCIATES PROVIDERS TO EVERY MEDICAL APPOINTMENT.**

_____
Patient Signature

_____
Date

Clayton S. Hall, D.O. & Associates, LLC

Medication Assisted Therapy Agreement

I understand that as a patient of Clayton S. Hall, D.O. & Associates, LLC ("**Hall & Associates**") I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several months.

1. **Consent to Evaluate/Treat**: I voluntarily consent that I will participate in an alcohol or drug assessment and/or treatment. I understand that following the assessment and/or treatment, complete and accurate information will be provided concerning each of the following areas:

- The benefits of the proposed treatment.
- Alternative treatment modes and services.
- The manner in which treatment will be administered.
- Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
- Probable consequences of not receiving treatment.

Treatment will be provided within the boundaries of Kentucky substance use disorder treatment laws.

2. **Benefits and Risks to Assessment/Treatment**: Assessment 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 assessment include diagnosis, assessment of recovery or treatment, estimating prognosis, and education and rehabilitation planning.

Possible benefits of treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations. I understand that while psychotherapy and/or medication may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. I realize that sometimes medications may have unwanted side effects.

3. **Charges**: Fees are based on the length or type of assessment or treatment, which are determined by the nature of the service. I will be responsible for payment for my treatment. The cost of services is available to me upon request.

4. **Confidentiality**: Information from my assessment and/or treatment is contained in a confidential medical record.

5. **Right to Withdraw Consent**: I have the right to withdraw my consent for assessment and/or treatment at any time by providing a written notice.

6. **Toxicology Testing**: I understand that throughout my course of treatment, I will be required to submit to a variety of toxicology tests to include urine drug testing, alcohol testing, pregnancy testing (if applicable), and blood/lab work testing. The provider will determine the frequency of these tests. I give my consent to undergo all tests described above as they apply to me.

7. **Expiration of Consent**: This consent to treat will expire two years from the date of your signature, unless otherwise specified.

8. **Informed Consent for Medication Assisted Treatment**: In accordance with evidence-based practices, Hall & Associates and its providers, upon assessment and evaluation and at the recommendation of a medical provider may prescribe various medications to patients in recovery. These medications are used in conjunction with group counseling, individual counseling, and family counseling. Any medication I receive may have an adverse reaction and/or possible side effects.

The goal of medication assisted treatment is to stabilize functioning and treatment may continue for relatively long periods of time and that periodic consideration shall be given for reduction of dosage and gradual weaning toward my complete withdrawal from the use of all drugs.

9. **Treatment with Buprenorphine (if applicable): Buprenorphine is an FDA approved medication for the treatment of opioid addiction**. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate addiction, including methadone, naltrexone, and some treatments without medications. The appropriate treatment plan for me will be determined by the providers at Hall & Associates.

10. **Use of buprenorphine**. If I discontinue buprenorphine suddenly, I will likely experience withdrawal. If I am not opioid dependent, I should not take buprenorphine as it could cause physical dependence. The medication I will be taking will likely contain both buprenorphine and an opiate blocker (naloxone). If the medication is abused by snorting or injection, the naloxone will cause severe withdrawal but when taken as directed, the naloxone has no effect.

I understand that I may withdraw from this treatment and discontinue when indicated the use of the medication at any time, and I will be afforded medical withdrawal under medical supervision. The medically supervised withdrawal could be either a short-term withdrawal or long-term withdrawal. If I am dependent on opioids, I **should be in as much withdrawal as possible when I take the first dose of buprenorphine/naloxone**. If I am taking methadone or other medications, I must inform Hall & Associates. Hall & Associates recommends that I arrange not to drive after my first dose, because some patients may experience drowsiness during the early phases of treatment. It may take several days to feel completely comfortable with the transition to buprenorphine/naloxone.

Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) can be dangerous. Although sublingual buprenorphine has not been shown to be liver-damaging, my primary care doctor will monitor my liver tests while I am taking buprenorphine. (This is a blood test.) Attempts to override the buprenorphine by taking more opioids could result in an opioid overdose. I agree not to take any other medication without discussing it with my provider first.

I understand that buprenorphine products and other medication assisted treatment medications may interact with other prescription medications, vitamins and nutritional supplements. Potential interactions include increasing or decreasing the level of buprenorphine products in my body or, in extremely rare instances, possibly causing an abnormal heart rhythm that has the potential to be lethal. I agree that it is my responsibility to provide documentation of all medication, vitamins and nutritional supplements I am taking on at least a monthly basis.

I have read and understand these details about medication assisted treatment, including risks and benefits. I understand there are alternatives and wish to be treated with buprenorphine if that is medication that the physician deems medically appropriate.

11. **Prescription maintenance.** I will not attempt to obtain any controlled substances, including opioid pain medicines, controlled stimulants, anti-depressives or anti-anxiety medicines from anyone, including another doctor, dentist or nurse.

I will not share, sell or trade my medication with anyone for any reason.

I will safeguard my medication from loss or theft. I understand that lost or stolen medicine will not be replaced.

I understand that refills of buprenorphine will be made only at the time of an office visit. I understand that there will be no early refills written for me.

I understand that in the event I am arrested or incarcerated related to legal or illegal drugs, refills for buprenorphine will no longer be issued.

12. **Treatment programs.** I agree that I will inform any doctor who may treat me for any medical problem that I am enrolled in a substance use disorder treatment program, since the use of other medications in conjunction with medication assisted treatment prescribed by the Hall & Associates may cause me harm. In addition, I agree that I am not currently enrolled in another treatment program at this time.

I understand State and Federal law prohibits dual enrollment in opiate treatment programs. I therefore give my consent to allow Hall & Associates to disclose my enrollment status, via fax or verbal confirmation, to all opiate treatment programs in accordance with state and federal law guidelines. I further give my consent to allow Hall & Associates to disclose my enrollment status, via fax, electronic transfer or verbal

confirmation, to a statewide Central Registry in accordance with State and Federal law as well as any other treatment program within a 150-mile radius.

[**For women who are or may become pregnant**] I will tell my doctor if I am or think that I may be pregnant because taking buprenorphine while pregnant may cause severe harm or death to my baby.

[**For women who are nursing**] I will tell my doctor if I am nursing because buprenorphine passes through breast milk and may cause severe harm or death to my baby.

I hereby certify that no guarantee or assurance has been made as to the results that may be obtained from alcohol and drug treatment. With full knowledge of the potential benefits and possible risks involved, I consent to assessment and treatment.

_____ _____

Patient Signature Date

4865-2095-5596, v. 2

Clayton S. Hall, D.O. & Associates, LLC

Patient Confidentiality Agreement

Clayton S. Hall, D.O. & Associates, LLC ("**Hall & Associates**") is a physician practice that provides behavioral health services including counseling and is subject to confidentiality requirements. Both the State and Federal Governments maintain laws and regulations regarding the confidentiality of medical records documenting behavioral health, mental health or substance use disorder services and treatment. Hall & Associates is bound by State and Federal laws of confidentiality of both mental health and substance use disorder services. Once an appointment is made, no information can be disclosed to anyone without your written permission on a specific Release of Information Form. During your first appointment, the policy on confidentiality and your rights to privacy as a patient will be discussed in detail.

What this means for you:

Hall & Associates will not share your information with a third-party without your written consent. Hall & Associates staff will work diligently to protect information provided in counseling sessions.

- Confidentiality does not apply to cases of reported or suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- In cases of medical emergency, information may be shared with medical personnel.
- On rare occasions, there will be a request from a court for your records. Hall & Associates may be required to share that information. Hall & Associates will make an effort to discuss with you any instances when records may be disclosed. Hall & Associates will make an effort to share only information which is deemed legally necessary.
- While Hall & Associates does not bill insurance companies, Medicare or Medicaid or other payors ("payor"), should you request that your medical records be released or provided to a payor, you must execute a specific release authorizing us to do so. If you do so, employees of the payor may see your private health information as well as your employer if your insurance is through your employer.

Your Responsibility:

It is also your responsibility to protect the confidentiality and privacy rights of other patients. Do not discuss other patients (names, diagnoses, etc.) with individuals outside of Hall & Associates. To protect your confidentiality and privacy, all patients must agree to honor this policy as well. If you are found to have breached this confidentiality policy, you may be terminated as a patient of Hall & Associates.

Please acknowledge that there may be instances where Hall & Associates must share your confidential information and you recognize that you are responsible for helping maintain the confidentiality of other patients. Discussing other patients with individuals outside of Hall & Associates may result in your termination as a patient of Hall & Associates.

_____
Patient Signature

_____
Date

4862-6363-2585, v. 1

Consent for Telepsychiatry Services

Dr. Clayton S. Hall, D.O. & Associates, LLC
3229 Summit Square Place
Suite 200
Lexington, Ky 40509

What is Telepsychiatry?
Telemedicine is the process of providing health care from a distance through technology, often using videoconferencing. Telepsychiatry, a subset of telemedicine, can involve providing a range of services including psychiatric evaluations, therapy (individual therapy, group therapy, family therapy), patient education and medication management.

Telepsychiatry can involve direct interaction between a psychiatrist and the patient. It also encompasses psychiatrists supporting primary care providers with mental health care consultation and expertise. Mental health care can be delivered in a live, interactive communication. It can also involve recording medical information (images, videos, etc.) and sending this to a distant site for later review.

Benefits of Telepsychiatry
Video-based telepsychiatry helps meet patients' needs for convenient, affordable and readily accessible mental health services. It can benefit patients in a number of ways, such as:

- Improve access to mental health specialty care that might not otherwise be available (e.g., in rural areas);
- Bring care to the patient's location;
- Help integrate behavioral health care and primary care, leading to better outcomes;
- Reduce the need for trips to the emergency room;
- Reduce delays in care;
- Improve continuity of care and follow-up;
- Reduce the need for time off work, childcare services, etc. to access appointments far away;
- Reduce potential transportation barriers, such as lack of transportation or the need for long drives; and
- Reduce the barrier of stigma.

While some people may be reluctant or feel awkward talking to person in a screen, experience shows most people are comfortable with it. Some people may be more relaxed and willing to open up from the comfort of their home or a convenient local facility. Also, this will likely be less of a problem as people become more familiar and comfortable with video communication in everyday life.

Telepsychiatry allows psychiatrists to treat more patients in distant locations. Psychiatrists and other clinicians need to be licensed in the state(s) where the patient they are working with is located. State licensing boards and legislatures view the location of the patient as the place where "the practice of medicine" occurs.

Although telepsychiatry has the disadvantage of the patient and psychiatrist not being in the same room, it can create enhanced feelings of safety, security and privacy for many patients.

Evidence for Effectiveness
There is substantial evidence of the effectiveness of telepsychiatry and research has found satisfaction to be high among patients, psychiatrists and other professionals. Telepsychiatry is equivalent to in-person

Consent for Telepsychiatry Services

care in diagnostic accuracy, treatment effectiveness, quality of care and patient satisfaction. Patient privacy and confidentiality are equivalent to in-person care.

Research has also found that overall experiences among all age groups have been good. There is evidence for children, adolescents and adults regarding assessment and treatment (medication and therapy). There are even people for which telemedicine may be preferable to in-person care, for example people with autism or severe anxiety disorders and patients with physical limitations may find the remote treatment particularly useful.

Telepsychiatry has been found especially effective with respect to the treatment of PTSD, depression, and ADHD.

In SUMMARY, there is robust evidence that shows Telepsychiatry improves patient outcomes and shows high patient satisfaction by meeting patients' needs for convenient, affordable and readily accessible mental health and substance abuse care.

Reference: **American Psychiatry Association**, APA
For more information, please visit **Psychiatry.org**

Risks of Telepsychiatry

Most common risks are technological and confidentiality issues. Technological risks would include: Improper or unavailable equipment; Equipment malfunctions, including audio and/or visual problems that may affect two-way communication of verbal & non-verbal information. Missed information can lead to errors in judgment by the practitioner. Risk of breeches or "hacking" of patient Protected Health Information (PHI) and HIPAA violations are rare, but possible. Environmental disruptions during Telepsychiatry appointments may decrease privacy. Preparing a quiet, private location in your home or office can minimize privacy risks.

Alternatives to Telepsychiarty

1. Traditional visit in the Psychiatrist's office. Tell your psychiatrist if you are dissatisfied or uncomfortable with Telepsychiatry appointments. *** New patients must be seen in the office for Initial Evaluations, unless the Psychiatrist deems a situation as a medical emergency and the patient cannot come to the office.**
2. Telephone Appointments. Although telephone technology can be quite effective and has many of the same risks & benefits as Telepsychiatry, the Telephone is NOT considered Telepsychiatry. Audio communication between patient and provider does not include visual information, which is often helpful. However, telephone appointments may be necessary in certain cases: travel barriers or restrictions; lack of Telepsychiatry equipment (phone, personal computer, camera, tablet, internet (WiFi) or lack of a cellular connection.

Patient Rights

I understand that the laws that protect my privacy and confidentiality of medical information also applies to Telepsychiatry and I can withdraw my consent at any time, inspect all medical information, may obtain copies of my medical record information and may release my medical records to anyone with my written consent. I understand that withholding or withdrawing my consent of Telepsychiatry services will not affect my future care or treatment in the future. I understand that my consent for Telepsychiatry care will remain in force, unless it is revoked by me or my provider.

Consent for Telepsychiatry Services

I understand that I may withhold or withdraw my consent for treatment by writing or contacting the office of Dr. Clayton S. Hall, D.O. & Associates, LLC, at:

3229 Summit Square Place
Suite 200
Lexington, KY 40509

Patient Responsibilities
Please read this section carefully. We need everyone's understanding, cooperation and flexibility!

BEFORE YOUR APPOINTMENT:

1. Call and speak with our Office Manager, Kim, and schedule an appointment. If you already have an appointment, call and verify the exact date and time of your appointment. ***** MAKE SURE YOU SCHEDULE YOUR APPOINTMENT AT A TIME AND LOCATION THAT WILL BE PRIVATE AND FREE OF INTERRUPTIONS!** We would appreciate payment for services at this time. Kim may gather additional information from you and give instructions about the Telepsychiatry process and answer any questions you may have.
2. Dr. Hall or your psychiatric provider will call you and send you a secure, HIPAA-compliant e-mail or text message.
3. **Complete & Submit this Telepsychiatry Consent Form.**

APPOINTMENT TIME:

1. Please be available for a phone call 1-hour before and 1-hour after your scheduled appointment time.
2. Make sure you create a safe, private, distraction-free environment for your appointment. Inform your provider if anyone can see or hear any part of your session. Patients may invite family or supportive persons to their appointments, but all names must be disclosed before the session begins.
3. If your home environment is not private, we will call you back when you have established a private setting.
4. **Recording of Sessions by audio or video is NOT ALLOWED.** This applies to both patient and provider.
5. If video technology is unavailable or problematic, the provider & patient may use the telephone to complete the session.

AFTER YOUR APPOINTMENT:

1. **Medications**. We will call, fax or electronically send your medication prescriptions to your designated Pharmacist, as soon as possible. In some cases, patients may pick up their prescriptions at our office (especially samples) or have your prescriptions mailed to you. In most cases, your Pharmacist will call you when your medications are due. *****Medications can be received only when they are due! Requesting early refills is unacceptable and may be a sign of misuse of medications. Keep medications safe from children, theft or damage.**
2. Call our Office at **859-333-1477** to schedule an appointment. If Kim is busy, she will call you back as soon as possible, hopefully by the end of the workday, so please try to be available. *****Please call our office if you change addresses, phone numbers, pharmacy information, emergency contacts, or any other personal information.**
3. Please be available to return all phone calls to our office in a timely manner. We may need to update your information, give you important information, or request blood work, urine drug screens or pill counts at our office or other designated site

Consent for Telepsychiatry Services

Reasons for Termination of Care
Dr. Clayton S. Hall, D.O. & Associates LLC may terminate patient care for the following reasons:

- Providing dishonest or misleading information;
- Not following agreed-upon treatment plans;
- Excessively missing, rescheduling or arriving late to appointments;
- Engaging in inappropriate, rude or disruptive behavior;
- Evidence of abuse, misuse or diversion of illicit or prescription medications;
- Failure to keep medications safe from children, theft or damage;
- Frequent requests to call in medications early; and/or
- Suspected illegal activity such as sharing or selling of medication, or legal charges or convictions during treatment.29 Summit Square Place

Patient's Name

First_____ Middle_____ Last_____

Patient's Birth Date _____

Last Four Digits of the Patient's Social Security Number_____

Patient's Primary Phone Number_____

Patient's Email Address_____

Patient's Street Address_____ Apt._____

City_____ **State**_____ **Zip Code**_____

Please DO NOT GIVE ANOTHER PERSON'S PHONE NUMBER OR EMAIL ADDRESS. This is very important for confidentiality.

Consent

By entering my name and checking the boxes below, I hereby certify that I have read, reviewed and understand the information provided above with regard to each of the following categories:

- What is Telepsychiatry?
- Benefits of Telepsychiatry
- Evidence of Effectiveness of Telepsychiatry
- Risks of Telepsychiatry
- Alternatives to Telepsychiatry

Consent for Telepsychiatry Services

- My Patient Rights
- My Patient Responsibilities
- Reasons for Termination of Care

☐ I also hereby Agree to and give Consent for the terms of Telepsychiatry Services listed above and agree to abide by these terms.

☐ I also confirm that all information I have provided herein is accurate to the best of my knowledge and understanding.

☐ **I Consent.**

Patient's Signature_____

Full Name (Print) _____

Date_____