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## Consent to Treat and Financial Agreement

**Consent to Treat.** You, for yourself, or as a personal representative of the patient, voluntarily consent to all medical treatment and health care-related services that the caregivers at Jovive Psychiatry PC (“Clinic”) consider to be necessary for the patient. You understand that caregivers include physicians, technicians, nurses, and other qualified personnel who shall perform services and procedures as may be necessary in accordance with the judgment of the attending medical provider(s). You are aware that the practice of medicine and treatment is not an exact science; no guarantees have been made about the results of treatments or examinations.

**Treatment.** Your care may include the following:

- Comprehensive psychiatric evaluation of the patient, including:
  - Assessing symptoms, history, diagnosis, and goals.
  - Discussing treatment options and recommendations, such as medication, therapy, or both.
  - Explaining the benefits, risks, and side effects of the proposed treatment.
  - Answering any questions.
- Collaboration to create a personalized treatment plan that suits your needs and preferences.
- Prescription of medication.
- Regular monitoring of treatment with support (i.e. support in treatment adjustments, making referrals as indicated, and possibly supporting outside of visits).
- Follow-up appointments at a cadence tailored to your needs.
- Care coordination with other providers upon receiving patient authorization.

**Services we do *not* provide.** The Clinic provides mental and behavioral treatment only. Your care will *not* include the following:

- We do *not* provide forensic services, disability validation, occupational assessment for employers, or court/custody involvement.
- We are unable to adequately support individuals requiring local behavioral health team involvement, including case management and/or therapists.

- Patients with severe symptoms rendering them disabled at the outset of treatment are not eligible for our services.
- Patients with substance use disorders must achieve early remission before being considered for treatment with our psychiatry practice.
- Concerns primarily related to executive functioning (e.g., dementia, head injury), communication (e.g., autism or receptive/expressive disorders), and most learning disabilities are not well-suited for our primarily virtual practice. Such cases should be managed by primary care with support from community-based resources.

**Medications and Coordination.** Patients currently prescribed controlled substances for medical reasons such as seizures or pain, not managed by another provider, are not accepted for treatment. New patients should either be off all sedative and opiate-based medications or have them managed by a provider who can coordinate treatment with our psychiatrist. For example, if a patient is using a fentanyl patch for chronic pain, their prescribing pain management doctor must be readily available for communication and coordination before the initial clinical encounter. Furthermore, patients currently taking sedatives (ex: benzodiazepines) or stimulants (ex: Adderall) prescribed by another provider while seeking treatment with us are *not* accepted.

Direct communication with the prescribing provider is necessary before scheduling the first clinical encounter. During your initial appointment, your provider will discuss medication treatment options, potential side effects, and how to manage them. You understand that you should not share your medication with anyone else or receive psychiatric medications from other providers without first informing the Clinic.

You understand alcohol and other drugs may compromise your treatment and make your symptoms worse and the Clinic recommends that you abstain from these substances while in treatment. Additionally, combining alcohol or opiates with benzodiazepines or hypnotics (like Ambien) is particularly dangerous and can be fatal. You understand that if you misuse medications or combine them with other substances, your medications may not be refilled.

**Confidentiality.** Your treatment is confidential. What you communicate during the course of treatment is protected by legal, professional, and ethical standards. Information gathered during the course of treatment may not be released without your prior written consent. However, California Law has placed specific limits on the confidentiality of this treatment relationship.

According to California State Law, this Clinic has a legal obligation to disclose treatment information under the following circumstances:

1. If the therapist determines, or has reasonable cause to believe, the patient is in such mental or emotional condition as to be dangerous to him/herself or to the person or property of another and the disclosure of confidential information is necessary to prevent the threatened danger. (Evidence Code 1024)
2. If a therapist knows or reasonably suspects a child is being abused or neglected. (Penal Code Section 11165)
3. If a therapist has reasonable knowledge or suspicion that a person over age 65 or a dependent adult has been physically abused. (California State Law)
4. In cases of threatened suicide, the therapist has a legal duty to take reasonable steps to prevent it.
5. If requested or authorized by the patient or compelled by court.

Note: We cannot guarantee that text messaging, email, and/or electronic receipts are secure or confidential forms of communication. You acknowledge these risks when you sign this form or opt to use those communication methods.

**Medical Photography/Recording.** You acknowledge that a copy of the patient's photograph ID may be taken for Chart identification and documentation purposes for the patient's electronic health record and is the property of Clinic unless consent is withdrawn in writing. If treatment requires medical photography (e.g., photographs, videos), you consent to such medical photography and consent to the use of these photographs and any other records for medical care and medical documentation purposes. You understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. You also understand it is your responsibility to assure those accompanying you comply with this requirement.

To serve you as well as possible, your provider may ask your permission to record sessions. These recordings are used only for private review by your provider. Your visit will not be recorded without your knowledge and consent. The recording will not become part of any ongoing record kept of your work here. You may stop the recording or change your mind about this agreement at any time.

**Self-Pay Agreement.** You have registered as a private pay patient. This means that at the time of service you will be paying by cash, check, or debit/credit card. We will not bill insurance for services provided under this arrangement. No documentation or forms will be produced now, or in the future, for you or us to submit for insurance billing.

I understand that I will be responsible for all charges related to the services provided to me by this Clinic.

I understand that the charges presented to me are due in full on the day of service unless arrangements have been made with the Clinic in advance.

**Missed Appointment Notification.** To provide optimal care to all of our patients, we ask that you give us a 24-hour notice if you need to cancel a scheduled appointment. Multiple missed appointments negatively impact our practice and the healthcare we provide to our patients. Therefore, at the discretion of the Clinic, if you have more than three "no shows" within a twelve-month period, you may be subject to dismissal from our practice.

**Termination.** You understand that your psychiatric care may be terminated, and you may be referred elsewhere if you do not follow treatment recommendations, including referrals, taking medications as prescribed, following up in the recommended time frame, following up with recommended higher level of care, or not adhering to the patient responsibilities. You understand that the Clinic may decline to continue providing care or recommended treatment at any time, and that the Clinic may ask that your psychiatry file be closed accordingly.

### **Acknowledgements**

California Consumer Privacy Act (CCPA). You may receive emails and text messages from us that will include updates on our clinic, general health news, and business updates. You can find more information about [Jovive's CCPA Policy](http://www.jovivepsychiatry.com) at [www.jovivepsychiatry.com](http://www.jovivepsychiatry.com) which informs you of the categories of Personal Information that we collect and the purposes for which those categories of Personal Information are used. You can unsubscribe at any time using the link included on all emails or using the

webform located within Vituity's CCPA Privacy Policy.

“ I agree to receive email and text communication from Vituity.

**Receipt of Notice of Privacy Practices.** You have received or have been offered a copy of the Notice of Privacy Practices which describes how the patient's health information may be used or disclosed by the Clinic. It is understood that this Notice is provided the first time the patient receives services and then only when a significant change to the Notice is made. Otherwise, it is available by request or on the clinic's website.

**Receipt of Patient Rights and Responsibilities.** You have received or have been offered a copy of the Patient Rights and Responsibilities which describe your basic rights and responsibilities as a patient of this Clinic.

**Receipt of Telehealth Consent.** You have received or have been offered a copy of the Telehealth Consent which describes the risks related to telehealth treatment.

Receipt of Copy of this Consent. You have received a copy of this fully signed and dated form and a copy will be retained in the patient's medical record maintained by the Clinic.

By signing below, you, as the patient or their personal representative, have read and understands this form and accepts its terms and conditions, and that it is being signed by the patient or the patient's authorized representative.

\_\_\_\_\_  
Patient/Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

If signed by the Personal Representative Provide Relationship to Patient: \_\_\_\_\_

## Telehealth Consent

### Overview of Telehealth.

Telehealth is a way to visit healthcare providers involving the use of electronic communications. You can talk to your provider from any place, including your home, without going to a clinic or hospital. Providers may include urgent care practitioners, primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include live two-way audio and video and other materials (e.g. medical records, data from medical devices). By signing below, you consent to engaging in telehealth with your provider.

### Your Rights.

You understand that you have the following rights with respect to my visit:

- You have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment
- The laws that protect the confidentiality of my medical information also apply to telehealth. As such, you understand that the information disclosed by me during the session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim or self; and where you make my mental or emotional state an issue in a legal proceeding. You also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without your written consent.
- You understand that my healthcare information may be shared with other individuals for treatment and healthcare operations purposes.
- You understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons. In addition, you understand that telehealth-based services and care may not be as complete as face-to-face services. You also understand that if my provider believes you would be better served by face-to-face services, you may be referred to a provider who can provide such services.
- You understand that you may benefit from telehealth but that results cannot be guaranteed or assured.
- You understand that you have a right to access my medical information and copies of medical records in accordance with state law.
- You understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in your community.

Receipt of Copy of this Consent and Financial Agreement. You have received a copy of this fully signed and dated form and a copy will be retained in the patient's medical record maintained by the Clinic.

By signing this consent, you or your personal representative have read and understand this form and you accept its terms and conditions

## Notice of Privacy Practices (NPP)



2100 Powell St Ste 400  
Emeryville, CA 94608

### VITUITY NOTICE OF PRIVACY PRACTICES (NPP) FORM 13.G.1.

#### **Your Information. Your Rights. Your Choices. Our Responsibilities**

Vituity® (Vituity is the trade name for CEP America, LLC and each of its member partnerships and subsidiaries) This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

**Your Rights:** You have the right to:

- Get a copy of your paper or electronic medical record
- Request confidential communication
- Get a copy of this privacy notice
- Get a list of those with whom we have shared your information
- Correct your paper or electronic medical record
- Ask us to limit the information we share
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### **Your Choices**

You have some choices in the way that we use and share information with family and friends about your condition.

**Our Uses and Disclosures:** We may use and share your information as we:

- Treat you
- Do research
- Comply with the law
- Work with a coroner, medical examiner, or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Respond to lawsuits and legal actions

We will not market or sell your health information.

#### **Your Rights**

**When it comes to your health information, you have certain rights.** This next section explains in more detail your rights, choices, and responsibilities, and our uses and disclosures of your information.

#### **Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information within 15 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.



**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

**Get a list of those with whom we have shared information**

- You can ask for a list (and “accounting of disclosures”) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the contact information below.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

<b>Your Choice</b>
<p><b>You can tell us your choices about what we share</b> with your family, close friends, or others involved in your care. If you have a clear preference for how we share your information, talk to us. Tell us what you want us to do, and we will follow your instructions.</p> <p><i>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.</i></p>
<b>Our Uses and Disclosures</b>
<p>How do we typically use or share your health information? We typically use or share your health information in the following ways.</p>

**To treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

### **To run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

### **To bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **To help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications
- Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls
- Reporting suspected abuse, neglect, or domestic violence

### **To do research**

We can use or share your de-identified information for health research. De-identified information means information which does not reveal your identity.

### **To comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

### **To respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

### **To work with a coroner, medical examiner, or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**To address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

<b>Our Responsibilities</b>
<ul style="list-style-type: none"><li>• We are required by law to maintain the privacy and security of your protected health information.</li><li>• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.</li><li>• We must follow the duties and privacy practices described in this notice and give you a copy of it.</li><li>• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.</li></ul> <p>For more information see: <a href="http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html">www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html</a>.</p>

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site, Vituity.com.

**Compliance Contact Information** You may:

- Reach our Compliance Team at [compliance@vituity.com](mailto:compliance@vituity.com)
- Contact our Chief Compliance and Privacy Officer, Emily Wang Zahn, JD, by email at [emily.zahn@vituity.com](mailto:emily.zahn@vituity.com) or by phone at 209-484-0112.
- Anonymously report a violation through our toll-free hotline 24/7 at 1-877- 3ETHICS (1-877-338-4427)

**Effective Date of this Notice:** November 14, 2022.