Way Center Patient Agreement

Welcome to the Way Center for Adolescent Mental Health. We are grateful to have the opportunity to help with your teens journey to mental and emotional wellness. This agreement explains our services and how we will work together

1) Services
    a. *In person physician office visits*: We emphasize the need for in-person visits to maximize the ability to relate to and connect with our patients. Initial visits are generally scheduled for 60 minutes and follow up visits for 30-45 min depending on the issue. These visits are scheduled with Dr Milobsky and often include speaking with the teen together with caregivers as well as speaking with the teen one-on-one.
    b. *In person therapy visits*: These visits are a crucial part of mental health recovery and ongoing personal growth. Therapy is scheduled with one of our in-house therapists. Appointments are scheduled for 50 minutes.
    c. *Telehealth*: Although we greatly emphasize the superiority of in-person visits, we recognize that certain situations may require the use of telehealth. Telehealth visits are most appropriate for established patients for follow-up visits.
    d. *Group Therapy:* We are constantly trying to find ways to give our teens more opportunities for growth during their mental health journey. We will periodically be offering group-therapy options during the year run by one of our therapists.
    e. *Way Wellness:* We are developing programs for our teens to focus on building preventative mental-health skills. Using modalities like Yoga, Meditation, and Breath Work, we hope to help teens build new skills for healthy coping. Details about specific programs will be announced throughout the year.
    f. *Addiction:* We often address addiction issues in conjunction with our overall mental health treatment. Dr Milobsky has specific expertise in medical management of addiction issues, including Opioid addiction. Treatment may require separate appointments.
2) Consent to treat
   You acknowledge, consent, and authorize Way Center and its providers to provide mental health treatment for your child or yourself. You recognize that this consent is given in advance of any specific diagnosis or treatment and that these services are voluntary. You have the right to refuse any service recommended.
3) Fees
    a. *Initial physician evaluation*: $450 to be paid at time of service

b. *Follow-up physician visits*: $200 to be paid at time of service
c. Med-check physician visits: $175 to be paid at time of service
d. *Therapy Service*: $100/hour for established Way Center patients to be paid at time of service. $180/hour for patients seeking therapy only and NOT working with a Way Center physician.
e. *Group Therapy and Way Wellness*: These rates will be announced at time the programs are announced.

4) Disclaimer of Non-Insurance

We accept NO commercial insurance for services at the Way Center. We do currently accept Medicaid. This agreement is not a Health Insurance plan or a substitute for healthcare coverage. As such, this agreement is not subject to health insurance protections provided for by state law.

5) Cessation

Patients have the right to leave the care of the Way Center at any time. We also reserve the right to terminate care under certain circumstances. Such circumstances may include, but are not limited to:

- Failure to pay fees and charges when due Failure to sign patient agreement;
- Failure to adhere to recommended treatment plan;
- Abusive, disruptive, violent, or threatening behavior towards the staff or other patients; or
- Way Center discontinues operation.

6) Privacy and Communication

- Your Privacy Rights: You acknowledge and authorize Way Center to use and disclose you or your child's health information that specifically identifies you or your child to carry out your treatment and for payment collection. Way Center will adhere to its obligation regarding your privacy rights as identified in our Privacy Practices Notification. Your signature attests that you have read, understand, and agree to our Notice of Patient Privacy Practices and that you have been given a copy.
- Methods of communication: You acknowledge that communication with Way Center may include e-mail, phone call, text messaging, video chat and cell phone. Communications, by their very nature, cannot be guaranteed to be secure or confidential. Way Center or any of our providers and staff shall not be held liable to you, or anyone, for any cost, damage, expense, injury, or other loss relating to Communication privacy, malfunction, or a delay in response.

Your signature below means that you have read, understand, and agree to all the terms and conditions contained in this agreement.

7) Cancellation Policy
Once an appointment is scheduled, you will be expected to pay for it, unless you provide at least 24 business hours advance notice of cancellation. For example, an appointment for Monday at 10:00 a.m. needs to be cancelled before 10:00 a.m. on the Friday to avoid a missed appointment charge. You will be charged for missing your appointment or failing to cancel with 24 hours' notice. If you wake up sick on the day of your appointment, you may convert your appointment from an in-person to telehealth visit. As a courtesy, you will receive a phone or text message (please let us know which you prefer) on the day before your appointment. Please realize that you are responsible for appointments that you schedule whether or not you receive this call or text. In event of inclement weather, it is your responsibility to call and cancel the appointment if you do not feel safe traveling.
8) Late Policy
Please arrive on time for your appointment. Patients arriving more than 10 minutes late may be asked to reschedule.
9) Confidentiality
Your privacy is important to us. All protected health information (PHI) will be kept confidential. In most cases we will obtain your consent prior to releasing any PHI; however, records and/or PHI may be released regardless of consent in the following circumstances:
    - According to state and local laws, we must report to the appropriate agencies all cases of physical and sexual abuse or neglect of minors (children under the age of 18), the disabled, and the elderly. · According to state and local laws, we must report to the appropriate agencies all cases in which there exists a danger to self and/or others.
    - When authorized by the recipient of services, in order to process medical insurance claims and authorized payment of benefits.
    - In the event that a patient is in need of emergency services and other medical personnel need to be contacted.
    - If you become involved in specific kinds of legal proceedings, the courts may subpoena information concerning your treatment.
10) Professional Records
The laws and standards of my profession require that we keep protected health information (PHI) about you in medical record. Except in unusual circumstances that involve danger to yourself or others, you may examine and receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be confusing if read without the guidance of a mental health professional. For this reason, we recommend that you initially review them in our presence or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $25.00 or more.

11) Patient Rights

HIPAA provides you with rights with regard to your clinical record and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records, and the right to request a paper copy of this Agreement.

12) Telephone Contact

If you have issues regarding your treatment that need to be addressed before your next appointment, please call our office by 4:00 PM. Staff will take a message and we will return your call later in the evening. Changes in your treatment plan will be addressed at the next visit.

13) Emergency/After-hours Service

If you are in need of emergency services, call 911 or proceed to the nearest hospital emergency room. If you have an urgent problem after hours which cannot wait until the next business day, you may call our office number 720-457-2400 and follow the recorded message instructions for how to contact us or the on-call physician. This option is reserved for urgent problems and does not apply to routine requests or scheduling issues.

14) Telephone Contact Fees

We have the option of charging you for telephone calls relating to your care. Charges are based on the amount of time spent and/or the complexity of the issue which is addressed.

Signature:_____Date:_____

Patient Name:_____Date of Birth:_____

Address:_____

Email_____

Phone:_____

Emergency Contact:_____

Emergency Phone: _____

Thank you for choosing The WAY Center to care for your teen. We look forward to partnering with you in managing their health and wellness.

FINANCIAL POLICY

It is mutually beneficial that you understand our financial policies. If you have any questions, please feel free to call us and we will be happy to provide clarity.

Payment for services is due and payable at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express. We require a credit card on file to hold an appointment for your child. This credit card will only be charged if you do not provide an alternate form of payment at the time of service.

We require a minimum of 24 hours' notice if you need to cancel or change an appointment. For no-shows or appointments cancelled or changed less than 24 hours in advance, we will charge an $80 missed-appointment fee to the card on file.

INFORMATION AS IT APPEARS ON YOUR CARD

Name: Number:

Expiration: Verification Code:

Billing Address:

City: Zip:

I understand the policies stated and agree to be responsible for payment of all services rendered to my teen(s).

_____ _____

Signature Date