NEW PATH PSYCHIATRY

1420 W Canal CT, Ste 20 Littleton CO, 80120
Tel: 720-466-1932
Fax: 720-802-7462
office@newpathpsychatryco.com
www.newpathpsychiatryco.com

INFORMED CONSENT

The following is important information regarding your clinical relationship with New Path PLLC, dba, New Path Psychology and its providers (collectively, "New Path"). Please review it carefully and let us know any questions you may have prior to signing.

PSYCHIATRIC EVALUATIONS. The purpose of a psychological evaluation is to evaluate and demonstrate elements of your emotional state and cognitive function. We want to put you at ease in the context of any such evaluation. We must also maintain impartiality for the integrity of our services and the report. Your evaluation may include discussion of emotional issues, lifestyle issues, behavioral patterns, and family or relationship dynamics. Methods may include clinical interviews, self- and observer-report questionnaires, and objective measures, and may involve referral to other evaluation providers, as indicated. This process requires effort on your part and may involve emotional risk or discomfort. There is no guaranteed outcome with regard to diagnosis or treatment recommendations. Additionally, diagnosis does not guarantee we will provide specific medication prescriptions or other services. A typical evaluation will include:

- An interview with you and potentially with close members of your family. The interview will help us understand important psychological, medical, and social background information, and your current level of cognitive and psychological functioning.
- Consultation with your attorney, if applicable.
- A review of medical, psychological, and other supporting documentation that help us have a better understanding of your psychological and emotional being.
- If necessary, we will administer psychological tests and questionnaires to assess potential, specific areas where you are having difficulties.
- Neuropsychological testing, as requested by you or your representatives, including for evaluation of potential cognitive problems such as a learning disability, dementia, or traumatic brain injury.
- Upon completion of the evaluation, a comprehensive, written report integrating our findings.

You have the right to participate in evaluation decisions and planning. You can accept or decline any recommended evaluation measures. You may withdraw this consent to evaluation at any time and will then be advised of the ramifications of such withdrawal from services.

SPECIAL NOTICE FOR ATTORNEY CASES AND COURT PROCEEDINGS. Any information you disclose to us in the course of an attorney-ordered evaluation will be shared with your attorney and likely become part of the documentation in your case. This means, any such information will be shared in court. We are not attorneys. Please consult your legal counsel for how your court proceedings will work, the nature and scope of our evaluation, and the use and scope of any evaluation in your proceeding. If we use any psychological measures or symptoms screening tools in your evaluation, we will try to ensure such measures has been validated for use you're your cultural background and language.

TELEHEALTH: Your sessions may include participation in "Telehealth," *i.e.*, psychotherapy or psychiatry at a distance and by electronic means. Any Telehealth will generally occur over real-time (i.e., synchronous) video conference, but the scope and method of services may vary as determined by your provider. Your provider may request periodic face-to-face meetings in the provider's discretion and will discuss that possibility with you when it arises. You must be in the state of Colorado in order to receive Telehealth services. If you are ever

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outside of Colorado when receiving our services, you agree to inform us of that fact prior to receiving them or participating in any treatment session.

The benefits of telehealth are providing flexibility and support for you while removing the barriers of travel, remote residence, poor weather conditions. Telehealth also can assist in continuity of care, efficiency of care, and convenience of the participants. Because Telehealth sessions take place remotely, however, there is an increased risk to the confidentiality of your treatment. We utilize a number of security and backup measures to reasonably protect the confidentiality and existence of information and materials related to your sessions. This includes the use of HIPAA-compliant video technology. We will use all reasonable efforts to maintain confidentiality and security in your information.

Your provider will provide a phone number or computer link to join each session. For video conferencing, there is not a requirement to install software; you will only need a good internet connection. In order to best serve you, other individuals at our office or our third-party servicers could have authorized or unauthorized access to your records or transmissions (for example, staff members or information technologists). Please be aware, that while we take the preservation of patient confidentiality and information very seriously, there are inherent risks in utilizing electronic records and transmissions. This includes the fact that electronic files can be corrupted and electronic connections may be monitored by other individuals without authorization. You are responsible for the confidentiality of your own Telehealth environment and must consider if any people in your home or office may be able to overhear the session. You should be aware of phone call and computer privacy: consider closing windows, locking or password protecting your screen before walking away from your computer, having appropriate malware installed on your electronics to prevent any loss of personal information, and consider who may have access to your information or electronics. When you agree to receive Telehealth services, you assume responsibility for all of these considerations. You additionally warrant you are capable of using the necessary technology and will ask for assistance if you are not.

We prefer face-to-face video visits to phone visits. In the event you are out of town, sick or need additional support, however, we will consider phone sessions as an alternative. Due to video conference Telehealth's reliance on technology, participation may require more technical competence to be optimal. There is also always a possibility of technology failure during a video conference Upon video session disconnection, you should try to log back in via the provided link. Your provider will do the same. If the internet is no longer available, however, your provider will call you to either resume the session via phone or to reschedule the session. If unable to connect via phone or internet, we will try to contact you by the next business day to reschedule the session. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Most research shows that Telehealth is about as effective as in-person professional services. Please be aware, however, that due to inherent limitations of Telehealth, not all visual or physical cues present during a face-to-face meeting will be available during a Telehealth session. Telehealth is not appropriate for anyone having thoughts of suicide, at risk of harming oneself or others, or otherwise in a crisis. If your provider reasonably believes any of these situations exist, the provider will request an in-person visit, or may recommend you go to their nearest emergency room or crisis center for an evaluation. In the event that there are concerns for your safety at the time of disconnection, and provider is unable to reconnect via phone or video, then the provider will call your local police department for a welfare check.

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PATIENT RIGHTS AND IMPORTANT INFORMATION.
You are entitled to receive information from your provider about the methods of evaluation, therapy, and treatment, the techniques used, the duration of your treatment, if known, and the fee structure. You can seek a second opinion from another provider or terminate our services at any time. In addition, you are encouraged to discuss any of our professional recommendations with your primary care physician, or any other licensed healthcare professional you deem appropriate. In a professional relationship, sexual intimacy is never appropriate. You should report any such behavior to the board that licenses, registers, or certifies the licensee, registrant, or certificate holder. You have a right against discrimination, including on the basis of race, age, gender, ethnic origin, disability, creed or sexual orientation. You also have a right to know your provider's qualifications. You are entitled to ask about education and training and any other relevant information that may be important to you regarding the provision of professional services to you. You have the right to request and obtain notes or other materials created during sessions, as permitted by law and our ethical obligations. You may request those materials during a session or by emailing or calling us at the below contact information.

VOLUNTARY PARTICIPATION.
Your participation in our services is at all times voluntary. You have the exclusive right to choose whether to remain in or terminate this relationship at any time, although any fees or costs incurred on your behalf prior to termination will remain your responsibility. Upon the cessation of any treatment or services, you also have the right to ask about and understand the consequences of stopping treatment.

DISCLOSURE OF PATIENT INFORMATION; MANDATED REPORTING.
Generally speaking, the information provided by and to the patient during psychiatric sessions is legally confidential and cannot be released without the patient's consent. There are exceptions to this confidentiality, some of which are listed at C.R.S. § 19-3-304, the HIPAA Notice of Privacy Practices you have been provided, as well as other exceptions in Colorado and Federal law. For example, nurses and psychiatric professionals are required to report child abuse to authorities, as well as any articulable and significant threat to a school, students, teachers, administrators or other school personnel. Confidentiality exceptions also exist for emergencies, pursuant to a court order, and to protect you or others from serious, foreseeable harm. We will attempt to identify and communicate to you any legal exception to confidentiality that may arise, we will take all reasonable efforts to inform you of it, if feasible. Please keep in mind that our employees may have access to your information. Our employees are bound by the same confidentiality requirements stated above. There may also be times we need to consult with another mental health or medical professional or colleague about issues raised in our sessions in order to best support you. Confidentiality is protected within consultation. If you have any questions about the scope of this confidentiality provision, please feel free to ask us about it. We are happy to discuss it with you in further detail.

ASSUMPTION OF RISK. By signing below, you, on behalf of yourself, your legal representatives, heirs, successors, and assigns, agree you have read and understood the above risks and alternatives and other information regarding entering into a professional relationship as contained within this informed consent and patient rights disclosure. You further choose to ACCEPT ALL RISKS ASSOCIATED WITH YOUR WORK WITH NEW PATH AND ANY OF ITS PROVIDERS, AGENTS, CONTRACTORS, AND AFFILIATES (collectively, the "New Path Parties") IN ANY FORM IN ORDER TO UTILIZE THE NEW PATH PARTIES' SERVICES OR RECEIVE SERVICES FROM THEM. YOU AGREE TO ASSUME ALL RESPONSIBILITY FOR ALL LIABILITIES RELATED TO THESE ITEMS AND EVENTS, INCLUDING BUT NOT LIMITED TO ALL FINANCIAL LIABILITIES FOR MEDICAL OR OTHER

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HEALTH TREATMENT AND MEDICINES RELATED TO THEM. YOU ACKNOWLEDGE THE ABOVE-DETAILED RISKS MAY NOT BE COMPLETE, AND YOU AGREE TO ASSUME ALL RISKS OF TREATMENT AND AS OTHERWISE DESCRIBED HEREIN, WHETHER FORESEEABLE OR NOT, AND REGARDLESS IF THEY ARE NOW KNOWN, SPECIFICALLY IDENTIFIED IN THIS AGREEMENT OR ITS ASSOCIATED CONSENTS OR RELATED DOCUMENTATION, OR ARE LATER DISCOVERED.

CHOICE OF LAW; VENUE.
By signing below, you understand and agree the law of the State of Colorado shall govern this Agreement, and all consents or other legally binding documents related to your treatment relationship with your provider at New Path and New Path itself, without regard to Colorado's choice of law principles. The courts located in Arapahoe County, Colorado shall be the exclusive venue for all disputes arising under this consent and agreement, relating to New Path's services, or your professional relationship with us, and you specifically waive any challenge or defense to venue in that jurisdiction.

IF YOU HAVE ANY QUESTIONS AS TO THE INFORMATION CONTAINED WITHIN THIS INFORMED CONSENT, INCLUDING REGARDING OUR METHODOLOGIES, OUR CLINICIAN'S QUALIFICATIONS, OR YOUR RIGHTS, OR IF YOU HAVE ANY QUESTIONS CONCERNING THE PROPOSED TREATMENT RELATIONSHIP, PLEASE ASK US NOW BEFORE SIGNING THIS CONSENT FORM. DO NOT SIGN THIS FORM UNLESS YOU HAVE THOROUGHLY READ AND UNDERSTAND THE INFORMATION CONTAINED IN IT.

CONSENT AND AFFIRMATION: I, the below-signed individual, have read and fully understand the above consent to treatment and patient rights disclosure. I understand my rights as a patient or as the patient's responsible party and give my consent and agree to receive mental health treatment pursuant to this agreement. I understand I should not sign this form if all items—including all of my questions—have not been explained or answered to my satisfaction, or if I do not understand any of the terms or words contained in these forms. If I decide to stop or amend my treatment regimen at any time, I will immediately contact my New Path provider to discuss that fact. I acknowledge I have been provided a copy of New Path's Notice of Privacy Practices, as contained below in this intake packet. I attest I am of sound body and mind, and willfully and voluntarily agreeing to treatment.

_____ _____
Signature of patient or responsible party Date

_____ _____
Printed name of patient DOB

If signed by Responsible Party, please state your name, relationship to / authority to consent for patient:

_____ _____
Name Relationship/Authority

_____ _____
Name Relationship/Authority

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HIPAA PATIENT CONSENT FOR USE AND DISCLOSURE OF PHI

I hereby give my consent for New Path LLC, dba, New Path Psychiatry ("New Path") to use and disclose my protected health information (PHI) about me to carry out treatment, payment and healthcare operations (collectively, "TPO"). Please refer to our Notice of Privacy Practices ("NPP"), separately provided to you, for more information on our privacy practices.

By signing below, I have understand and agree I have the right to review the NPP prior to signing this consent. I understand New Path reserves the right to revise its NPP at any time. I may obtain a current NPP by requesting it in writing to New Path at 9249 S Broadway Ste 200-406, Highlands Ranch, CO 80129.

By signing below, I understand and agree New Path may call my home or other alternative location as communicated by me and leave voice mail or in person reference to any items that assist New Path in carrying out my TPO, which may include but will likely not be limited to appointment reminders, insurance items, and any calls pertaining to my clinical care such as laboratory test results (collectively, "TPO Information"). By this consent, I additionally authorize New Path to send TPO Information to my home address on file. I understand New Path will mark such communications "Personal and Confidential."

Because emails sent over the Internet or texts sent over the control channel without encryption may not be secure, I understand and agree to assume all risks associated with communications I make to New Path through email, text, or over the Internet (collectively, "Communications"), including, without limitation, the interception of Communications by unknown third parties; improper use and altering of information within Communications; backup copies of Communications existing even after the sender and receiver have deleted them; and Communications that contain harmful viruses or malware.

I understand I have the right to request New Path to restrict how it uses or discloses my PHI to carry out TPO. I understand New Path is not always required to agree to my requested restrictions, but if it does, it will be bound by that agreement.

I understand I may revoke this consent at any time in writing, received by New Path, except to the extent New Path has already made disclosures in reliance upon my prior consent. I understand that if I do not sign this consent, or later revoke it, New Path may decline to provide treatment to me.

_____ _____

Signature of patient or responsible party Date

_____ _____

Printed name of patient DOB

If signed by Responsible Party, please state your name, relationship to / authority to consent for patient:

_____ _____

Name Relationship/Authority

_____ _____

Name Relationship/Authority

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NEW PATH PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS

The standard meeting time for the initial visit is 45-60 minutes and follow up visits are 15-30 minutes. Payment is due within 24 hours of your appointment. You may lose your appointment if payment is not received within 24 hours of your scheduled time. Cancellations and re-scheduled visits will be subject to a full charge if NOT RECEIVED AT LEAST 48 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for an appointment, you may lose some of the allotted time for that appointment. Your card will automatically be billed 24 hours prior to your appointment if payment is not received.

NO SHOWS/ LATE CANCELLATION

Due to difficulties in fulfilling all required appointments, any missed appointment without appropriate notice, and any failure to appear at the scheduled appointment time, will constitute a "No-Show." We reserve the right to refer you to another provider or higher level of care, or to terminate services after a total of three No-Shows.

COLLATERALS' PARTICIPATION.

There may be times during our professional relationship where you want or we decide it is important to include a family member, friend, spouse, or other "collateral" in your treatment. Our primary legal and ethical obligations in any such situation will always remain with you. Please understand that including a collateral in your treatment may implicate the applicable professional/patient privilege, including constituting a waiver of any such privilege by including a third-party in those communications. Other protections such as spousal privilege may apply. Due to these considerations, however, we may ask any collateral to enter into a confidentiality agreement in order to protect the information communicated during any interaction with us in a session or visit. Please let us know if you would like to discuss these issues further prior to incorporating a collateral into your treatment.

EMERGENCY CONTACT COMMUNICATIONS

In the case of an emergency, your provider may need to self-identify or provide your protected health information ("PHI") to the Emergency Contact(s) you have provided to us. By signing below, you authorize us to communicate with that Emergency Contact if we deem there to be an emergent safety concern.

IN CASE OF A MENTAL HEALTH EMERGENCY, PLEASE CONTACT COLORADO CRISIS SERVICES (https://coloradocrisisservices.org/ - 1-844-493-TALK (8255)). The Suicide and Crisis Lifeline may be reached by calling or texting 988.

IN CASE OF A SUBSTANCE MISUSE OR ADDICTION CRISIS, PLEASE CONTACT THE COLORADO ADDICTION HOTLINE: 1-866-210-1303.

IN CASE OF A MEDICAL EMERGENCY, YOU SHOULD SEEK IMMEDIATE MEDICAL ATTENTION OR EMERGENCY CARE BY IMMEDIATELY GOING TO AN EMERGENCY ROOM OR BY CALLING 911.

TELEPHONE ACCESSIBILITY

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If you need to contact us or your provider between sessions, please call our main number or send us a message through our website. We are not a crisis clinic and may not be immediately available, especially outside of regular business hours. We will attempt to return your call within two business days. If we are reasonably concerned for your safety, we may contact Colorado Crisis Services or your on-file emergency contact(s). Your providers additionally reserve the right to contact the local police department if they believe you are an immediate threat of violence to yourself or any third party. By signing below, you authorize the contact detailed in this section, even in non-emergent situations.

MINORS

We generally require parental consent from both parents for all professional services. We also require at least one parent or legal guardian to be present during a portion of the visit to go through informed consent and to answer any questions or concerns the parent or guardian may have regarding the minor's treatment. If appointments are made by a legal guardian, you agree to provide documentation verifying proof of guardianship.

If you are a minor, your parents may be legally entitled to some information about your treatment. We take disclosure of minor information seriously and will generally use our clinical judgment, within the limitations of applicable law, to decide what and to what extent privacy is central to furthering a minor's treatment. We will attempt to address with you any information that could be shared with a parent or legal guardian before you share it, if possible. We will generally engage a minor patient in a frank discussion about the importance of including parents/guardians in the minor's treatment plan and will encourage the minor patient to do so.

If you are a parent or legal guardian of a minor in treatment with us and have questions as to the nature or scope of his, her, or their treatment, or as to what information we may share, please discuss those matters with us. Please note, in situations of divorce, custody, or other proceedings, our ability to discuss these issues with a patient's parent or guardian may be limited by court order or applicable law.

TERMINATION

We can terminate treatment with you at any time in our therapeutic discretion due to several reasons including non-compliance or aggressive behaviors. We will not terminate our relationship, however, without first discussing and exploring the reasons and purpose of terminating, unless such conversation would be unreasonable in the context of the relationship. If treatment is terminated for any reason, we will provide you with a list of qualified providers to continue your care. You may also choose someone on your own or from another referral source. Should you fail to not show up for your follow up appointments, not obtain lab work in a timely fashion or are non-compliant with treatment, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider the professional relationship discontinued.

SCHEDULED MEDICATION AGREEMENT

Our providers are not obligated to continue controlled substance prescriptions written by other providers. After careful assessment with history, review of PDMP and clinical guideline review, we will develop an appropriate plan of care to determine continuation or new prescription of controlled medications. At the discretion of the provider, certain lab work may be ordered to include but not limited to blood work or urine assessment. Any necessary tapering of current medications will be discussed during our sessions.

LITIGATION AND COURT PROCEEDINGS

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By signing below, you understand and agree that if you are ever involved in a divorce or custody litigation or otherwise involved in the court system, our roles as your provider is not to make recommendations for the court concerning custody or parenting issues. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans. If you choose to subpoena our providers to testify on your behalf, you agree to pay the provider the rate of **$450/hour** for all reasonable preparation time, travel time, and time at or in court or deposition.

RECORDS RETENTION

Subject to other legal or ethical obligations, your records may not be maintained after seven (7) years. For minor patients, records will be retained for a period of seven (7) years commencing either upon the last day of treatment or when the child reaches eighteen years of age, whichever comes later, but in no event shall records be kept for more than twelve years.

BY SIGNING BELOW, I AGREE I HAVE READ, UNDERSTOOD AND AGREE TO BE BOUND BY ALL THE PROVISIONS CONTAINED HEREIN:

_____ _____
Signature of patient or responsible party Date

_____ _____
Printed name of patient DOB

If signed by Responsible Party, please state your name, relationship to / authority to consent for patient:

_____ _____
Name Relationship/Authority

_____ _____
Name Relationship/Authority