CLIENT TREATMENT AGREEMENT AND CONSENT TO TREAT

Michael Dickerson DNP, FNP-C

8016 State Line Road, #205 Prairie Village, KS 66208
Phone: (913) 251–9207 Fax: (816) 264–6926

Welcome to the offices of Michael Dickerson, DNP. Please thoroughly read this document which contains important information about my professional services and business policies. This completion of this paperwork is required prior to the scheduling of your first appointment. A Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI), is also posted in the reception area.

If you have had any lab-work in the past year, please obtain a copy and bring it to your first appointment. You can have it faxed to our office (816) 264–6926, or attach it in a text via the Spruce app which is encrypted.

The law requires that I obtain your signature acknowledging that I have provided you with this information and that you have agreed to its terms. When you sign this document (physically or electronically), it will represent a contract between us. You may revoke this contract in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or monies owed in connection with treatment.

Please note that currently all visits are via Telehealth using Spruce Communications, unless otherwise specified by our office.

________(initial) I understand that unless otherwise specified by the office, my appointment will be conducted via Telehealth using Spruce Communications.

PAYMENT OF SERVICE

Payment is required at the time of each visit and I accept cash, check, credit, debit, FSA and HSA cards as forms of payment. There will be a $25 charge for any returned check. You will be responsible for the fees that are charged in connection with your treatment. My fee for psychiatric appointments is $250.00 for the initial visit and $150.00 for any visit following. My fee for any other appointment is $120.00 for the initial visit and $60.00 for the follow up. I will submit claims directly to insurance companies for which I am a contracted provider.

I cannot guarantee payment by your insurance company. If your claim is not paid, it will be your responsibility. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon in advance, I have the option of using legal means to secure the payment. This may involve employing the services of a lawyer or agency for collection purposes. In most collection situations, the only information I release regarding a Client's treatment is his/her name, the nature of the services and the amount due or other PHI allowed by HIPAA (Health Insurance Portability and Accountability Act).\

I AGREE TO THE FOLLOWING BILLING PRACTICES/STIPULATIONS:

________(initial) My copay will be billed the day before or day of my appointment, if my payment does not clear, I will be contacted for another form of payment. If I have not met my deductible, I understand the entire visit fee will be charged instead. This fee is based on individual contracted rates with your individual insurance. Should we cancel your appointment for any unforeseen reason, your payment on file will be reimbursed.

________(initial) Failure to cancel an appointment 24 business hours Monday thru Friday prior to the scheduled time will result in a $75 fee. You may notify us via text to the main practice phone line at (913) 251–9207. Communications are timed and date stamped.

________(initial) Every effort is made to communicate in a timely fashion; however, I understand provider contact is not available outside of the clinic hours. Normal business hours are Monday thru Friday 8 am to 5 pm. Most calls received prior to 12:00 noon are returned the same day, however, calls made after that time may be returned the following business day. Most non-urgent questions should be reserved to the following scheduled appointment. In the event of an emergency, I understand I should call 911 or go to the nearest Emergency Room for assistance.

________(initial) Prescription refill requests should be requested directly by your pharmacy. Please have them fax (816) 264–6926 all refill requests or medication inquiries on your behalf.

________(initial) I understand that remaining balances can not be carried over from appointments. My appointment must be paid in full prior to my next appointment. Failure to pay your balance in full before your next appointment or to make arrangements to have your balance paid in full by your next appointment can result in cancellation of your next appointment and/or termination from care.

FEES FOR ADDITIONAL SERVICES:

Your insurance company does not typically reimburse for activities that are not a part of direct Client care. The following is a list of some activities where an additional fee is required to be paid in advance.

1. Copying your clinical record (rate based on prevailing community standard)

2. It is preferred that most medical accommodation, FMLA, letter or report, or other paperwork be completed during a Client visit to ensure accuracy, any such paperwork not completed during a regular visit may be charged an additional fee, $175 an hour.

3. Time spent away from the office to testify in court, $175 an hour.

Consultation with other entities including but not limited to attorney, school, disability insurers, workmen's compensation ($175 an hour).

________(initial) I understand the above costs required for any additional services by Michael Dickerson.

CONFIDENTIALITY

The law protects the privacy of all communications between the Client and the provider, social worker, or other medical provider. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements by HIPAA. Your signature on this agreement provides consent for release of information consistent with HIPAA and state law.

A summary of the circumstances in which I may disclose private health information (PHI) without your consent is as follows:

1. If there is a situation that is potentially life threatening.
2. When child abuse is known or suspected. (Reporting required by state law).
3. When the abuse of an elderly or dependent person is known or suspected. (Reporting required by state law).
4. If you commit a crime against a staff member or another person on the premises.
5. If you bring charges against, or sue, your provider.
6. When ordered by the court.
7. In some cases, details of your treatment may be discussed with another clinician for the purpose of consultation. When this is done, no identifying information will be included (ie, the Client is anonymous).
8. In some cases, records may be audited by the quality improvement activity of your insurance company.
9. If it becomes necessary to refer your account to a collection service. Only information to pursue collection will be released.

________(initial) I understand the above circumstances in which Michael Dickerson does not need my permission to disclose private health information.

SPRUCE APPLICATION — TELEHEALTH AGREEMENT

Depending on the situation, your provider may approve your appointments to be conducted via Telehealth using the HIPAA protected Spruce Communications App. It is required by law that you be present in the state of Kansas or Missouri at the time of your Telehealth call. In the event you are not present in either state, please call the office to cancel your appointment. Please review the following statements and initial:

1. I understand that I am required to use the Spruce Communication desktop, IOS or Google app for my telecommunication between my provider and myself for evaluating, testing, and diagnosing my medical conditions.
2. I understand that in the event technical difficulties occur during my telehealth session, my appointment may not be started or ended as originally intended.

3. I accept that my provider can contact interactive sessions via video call; however, I am informed that the sessions can be conducted via regular voice communication (phone call) if the technical requirements such as internet speed are unable to be met.

4. I understand that my current insurance may not cover the additional fees of the telehealth practices, in this circumstance I may be responsible for any fee that my insurance company does not cover.

5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in any of these, my information will follow the office confidentiality policies as stated in this form.

________(initial) I agree to the above terms and conditions that require my compliance to be serviced via Telehealth.

SPRUCE APPLICATION AGREEMENT — TEXTING

________(initial) Using a secure texting app is the most efficient way to communicate with our office and your provider. I agree and understand that most communications are completed via the Spruce application. Once your paperwork is completed and submitted, you will receive an invite to download the Spruce app on your phone or computer so we may communicate in a secure and encrypted manner. You can accept this invite on your phone or download the Spruce app via a web browser after you receive our invitation.

________(initial) While communicating using the Spruce app, your messages are secure and private whether on your phone or computer. Should you text us outside of the app using SMS, your communications may not be secure. Therefore, we always advise that you use the Spruce app every time you have non-urgent communications. If a conversation requires more detail than texting can accommodate I understand my provider may call me directly and choose not to use the Spruce app for more urgent communications.

________(initial) Texting in the Spruce app is not meant to be used for emergency purposes. I understand should I have a mental health emergency, I should call 911 or go to the nearest emergency room.

PARENTS OF MINORS ONLY

Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Parents will need to sign a permission to treat form for services provided to a minor. In divorced families, Clients under 18 need the consent of the custodial parent(s). A copy of the divorce decree may be requested prior to initiating evaluation and treatment.

________(initial) I verify that I do have legal custody of this child.

If any of these policies or procedures cause problems or seem confusing, please speak with me, so that I may clarify them for you. I make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance

company files. I have no control over what they do with the information. In some cases, they may share the information with a national medical database.

By signing this Agreement, you agree that I can provide the necessary information to your insurance carrier or other designated third-party payers such as Medicare to process claims and for quality assurance activities.

By signing the agreement below I am acknowledging that I have reviewed the entirety of this Client Treatment Agreement and Consent to Treat document. I have read these policy statements and having been informed to my satisfaction, I give consent to treatment and/or evaluation by Michael Dickerson APRN. I understand that by signing this agreement I am acknowledging that I understand the content on this form and agree to comply with all aspects of it.

____

Client Signature Date

____

Parent/Guardian Signature (If Client is a minor) Date

CONSENT FOR MEDICAL RECORD RELEASE & AUTHORIZATION FOR DISCLOSURE

Client Consent to Exchange Information with My Primary Care Physician, Therapist or other Specialist. HIPAA policy allows collaboration between healthcare providers regarding your care.

I, ________________________________ , hereby authorize Michael Dickerson DNP, to:

________(initial) disclose information to

________(initial) obtain information from

________(initial) exchange information with

Name of Organization/Medical Provider:____
Address:____
City:_________________________State:_______________Zip:__________
Phone:__________________________ Fax:__________________________

The following information:

________(initial) Summary of treatment to include dates of contact, diagnosis, prognosis, treatment plans, intake summary, medications, laboratory results, genetic testing results, substance abuse treatment, and hospital records including discharge summaries.

The purpose of this request:

- Assist the person or organization to which the disclosure is being made in their provision of services

- Obtain information important in evaluation and treatment of the client and to provide information to the person(s) or organization to which disclosure is being made.

This consent to disclose may be revoked by me at any time upon my written request except to the extent action has been taken in reliance theron. This consent (unless expressly revoked earlier) will expire one year after the close of the case.

I acknowledge that I am aware that certain information I am consenting to release is confidential and protected by Federal and State Law. I acknowledge upon signing this consent that I am waiving my rights under these laws and that I am aware of the specific protections I am afforded or I am waiving my right to being informed of the specific provision of these laws. Statute – 42 CFR-Part2. K.S.S 65-5601 to 65-5605, inclusive.

It is expressly understood that photocopies/fax of this authorization shall be as valid as the original.

By my initials below,

I authorize exchange of information with my/my child's Primary Care Physician, Therapist, or other healthcare provider. I place no limits on dates, history of illness, diagnostic and therapeutic information, including treatment for alcohol and/or drug abuse.

Please list providers/individuals that you would like permission to collaborate or release information regarding your care:

Physician/Therapist name:____

Phone:_____________________________Fax:______________________________

Physician/Therapist name:____

Phone:_____________________________Fax:______________________________

Physician/Therapist name:____

Phone:_____________________________Fax:______________________________

________(initial) I hereby authorize the offices of Michael Dickerson to disclose my medical records, genetic results, and labs to the above parties. In the event I want to change the name of a physician or family member that has permissible disclosure, it is my responsibility to contact the office of Michael Dickerson, and or submit a new form. I have completed in full the information above to the best of my knowledge and ability.

____

Client Signature Date

____

Parent/Guardian Signature (If Client is a minor) Date

CONTROLLED SUBSTANCE AGREEMENT

The following agreement is required for all clients who will be prescribed controlled substances by Michael Dickerson, DNP. Since it has yet to be determined whether or not controlled substances will be a part of your care, please still fill out this form so that our office can have it on file for future use.

I,________________________________, understand that if my healthcare provider, Michael Dickerson, DNP, has prescribed me controlled substances for the treatment of my medical condition, this treatment may carry risks and benefits, and that the effectiveness of the treatment may depend on how strictly I adhere to the prescribed regimen.

As a part of my treatment plan, I understand and agree to the following guidelines:

________(initial) I will only use the prescribed medication as directed by Michael Dickerson, DNP. I will not alter the dose, frequency or route of administration without first consulting my healthcare provider.

________(initial) I will not share my medication with anyone else, nor will I obtain medication from any non-prescribed sources.

________(initial) I will report any side effects or adverse reactions to my healthcare provider immediately.

________(initial) I understand that long-term use of controlled substances can lead to physical and psychological dependence, and I will notify the office of Michael Dickerson, DNP LLC if I feel like I am becoming dependent on the medication.

________(initial) I agree to submit to random drug screening as required by my provider, and understand that refusal to submit to a drug screen may result in discontinuation of my medication.

________(initial) I understand that my healthcare provider, Michael Dickerson, DNP, may need to consult with other healthcare providers and utilize prescription drug monitoring programs to ensure safe and responsible prescribing.

________(initial) I will keep my medication in a secure location and out of reach of children or pets.

________(initial) I agree that I am responsible for my medicine. I will not share, sell, or trade my prescription and I will not take anyone else's prescriptions. I understand doing so is a felony.

________(initial) I understand that if my medicine is lost, stolen or used sooner than prescribed, it will not be replaced.

________(initial) I agree to keep all appointments set up by the office of Michael Dickerson, DNP..

________(initial) I understand that if I need to stop this medicine, I must do so slowly or I may become very sick. If you become pregnant please contact the office immediately.

________(initial) I understand that I may be asked to comply with additional guidelines as deemed necessary by Michael Dickerson, DNP, given my specific treatment plan.

________(initial) I understand that the Drug Enforcement Agency governs the rules regarding the writing of controlled substances and if a Client can be seen via telehealth or must be in office for their

scheduled appointments. These laws are subject to change and I understand I may be required to be seen in person and may not be able to use telehealth if rules change at any time in the future.

TERMINATION OF CONTROLLED SUBSTANCE AGREEMENT

If I break any of the rules, or if my provider, Michael Dickerson, DNP, decides that this medicine is hurting me more than helping me, this medicine may be stopped by him in a safe way.

PROVIDER RESPONSIBILITIES

As your provider, Michael Dickerson, DNP, I agree to perform regular checks to see how well the medicine is working.

I agree to provide healthcare care for you even if you are no longer getting controlled substances from me except in the event I am required to terminate care.

NEW CLIENT INFORMATION

First Name:__________________ Last Name:___________________ MI:______ DOB:______________
Gender (Sex at birth): ▫ M ▫ F | Gender Identity: ▫ Male ▫ Female ▫ Trans ▫ Non-binary
Marital status: ▫ Single ▫ Partnered ▫ Married ▫ Separated ▫ Divorced ▫ Widowed
Address:______________________________ City:_________________ State:_______ Zip:___________
Cell Phone:______________________ Email:____
Employer Name:______________________________ Employer Phone:__________________________
Emergency Contact #1:____
Relationship:______________________________ Phone:______________________________
Emergency Contact #2:____
Relationship:______________________________ Phone:______________________________

INSURANCE INFORMATION

Insurance:_______________________________ ID#:__________________ Group #:_________________
Policyholder Name (if not client):___________________________________
Relationship:_______________________ Phone:____________
Insurance:_______________________________ ID#:__________________ Group #:_________________
Policyholder Name (if not client):___________________________________
Relationship:_______________________ Phone:____________
Prescription Insurance (if separate from medical insurance):__________________________________
ID#:____________________________________ RX BIN#:____
RX PCN#:____________________________________ RX Group#________________________________

CLIENT REPORT OF PROBLEM

Briefly describe your reason(s) for seeking help: ____
____
How long have you had the issue? ____
What other ways have you tried to deal with this problem? ___________________________________
____
Is there anything else you'd like me to know prior to our first appointment: ___________________
____
____

MEDICAL HISTORY

Diagnosis:____Year:______________
Diagnosis:____Year:______________
Diagnosis:____Year:______________
Diagnosis:____Year:______________
Diagnosis:____Year:______________
Diagnosis:____Year:______________
Diagnosis:____Year:______________
Diagnosis:____Year:______________
Diagnosis:____Year:______________
Diagnosis:____Year:______________

PRIOR OUTPATIENT COUNSELING/PSYCHIATRY

Therapist Name:______________________Dates Seen:___________ □ Helpful □ Unhelpful
Therapist Name:______________________Dates Seen:___________ □ Helpful □ Unhelpful
Therapist Name:______________________Dates Seen:___________ □ Helpful □ Unhelpful
Therapist Name:______________________Dates Seen:___________ □ Helpful □ Unhelpful

PRIOR HOSPITALIZATIONS

Facility Name:______________________ Reason:__________________ Date: _________
Facility Name:______________________ Reason:__________________ Date: _________
Facility Name:______________________ Reason:__________________ Date: _________
Facility Name:______________________ Reason:__________________ Date: _________
Facility Name:______________________ Reason:__________________ Date: _________

FAMILY HEALTH HISTORY

Relationship:______________________ Health Problem(s): __________________________
____
Relationship:______________________ Health Problem(s): __________________________
____
Relationship:______________________ Health Problem(s): __________________________
____

FAMILY MENTAL HEALTH HISTORY

Relationship:____________________________ Mental/Emotional Problem(s):______________________

____

Relationship:____________________________ Mental/Emotional Problem(s):______________________

____

Relationship:____________________________ Mental/Emotional Problem(s):______________________

____

CURRENT MEDICATION AND SUBSTANCE USE

Are you currently using any form of marijuana? (products containing THC, or CBD): ☐ Yes ☐ No

In what way are you ingesting? ☐ Smoking (or vape) s ☐ Edibles ☐ Pills or Liquid ☐ Other

Frequency of use: ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally

Amount/Grams per week?______________________

Reason you started using: ☐ Physical Pain ☐ Anxiety/Depression ☐ Recreational ☐ Other

Age at first use of marijuana:______________________

Are you currently drinking alcohol? ☐ Yes ☐ No

Have you ever abused alcohol? ☐ Yes ☐ No ☐ Unsure

Frequency of use: ☐ 3+ Drinks Daily ☐ 1-2 Drinks Daily ☐ 1-2 Drinks Weekly

☐ A few drinks a Month ☐ On Occasion

Is there a specific reason you drink: ☐ Pain/Numbing ☐ Anxiety/Depression ☐ Socially ☐ Other

Are you aware of any alcohol dependency in your family? ☐ Yes ☐ No ☐ Maybe/Unsure

CURRENT MEDICATION USE

Medication Name:_____________________________________ Dosage:___________________________

Medication Name:_____________________________________ Dosage:___________________________

Medication Name:_____________________________________ Dosage:___________________________

Medication Name:_____________________________________ Dosage:___________________________

Medication Name:_____________________________________ Dosage:___________________________

Medication Name:_____________________________________ Dosage:___________________________

Medication Name:_____________________________________ Dosage:___________________________

Medication Name:_____________________________________ Dosage:___________________________

Medication Name:_____________________________________ Dosage:___________________________

PRIOR PSYCHIATRIC MEDICATION USE

Medication Name:______________________________ Was it helpful? ☐ Yes ☐ No ☐ Not sure

Year(s) taken:________ Diagnosis:__________________ If you had a negative reaction, explain:

____

Medication Name:______________________________ Was it helpful? ☐ Yes ☐ No ☐ Not sure

Year(s) taken:________ Diagnosis:__________________ If you had a negative reaction, explain:

____

Medication Name:______________________________ Was it helpful? ☐ Yes ☐ No ☐ Not sure

Year(s) taken:________ Diagnosis:__________________ If you had a negative reaction, explain:

____

ALLERGIES TO MEDICATIONS

Medication Name:______________________________ Reaction:______________________

Medication Name:______________________________ Reaction:______________________

Medication Name:______________________________ Reaction:______________________

Medication Name:______________________________ Reaction:______________________

Medication Name:______________________________ Reaction:______________________

Medication Name:______________________________ Reaction:______________________

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled. Your card will be charged the day of your visits. If you would like to organize a payment plan you must do so prior to your appointment. Charges can not be refunded after they have been processed, unless due to clerical error.

Primary Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other:__________
Cardholder Name (as shown on card):
Card Number:
Expiration Date (MM/YY):
Security Code (3-digit):
Cardholder ZIP Code (from credit card billing address):

Secondary Card Information (If Necessary)
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other:__________
Cardholder Name (as shown on card):
Card Number:
Expiration Date (MM/YY):
Security Code (3-digit):
Cardholder ZIP Code (from credit card billing address):

I ______________________, authorize the Office of Michael Dickerson to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.