Patient Service Agreement and Consent Form

SG Integrative Psychiatry and Wellness ("Provider") is proud to provide you with personalized support and care. Please read and sign the following agreement; it lists our billing, scheduling and cancellation policies and procedures. If you have any questions, please ask for clarification.

1. **Scheduling Services.** All services can be scheduled by using Alma's website or going to providers website (www.sgipw.org), by phone by calling Provider at 844-744-7944 or sending an SMS to 509-401-8060 or by emailing Provider at info@sgipw.org or finding provider on psychologytoday.com. If you schedule an appointment or communicate with Provider via email, you are consenting for Provider to respond to your email utilizing the same method, even if you have not completed the email and text consent you will receive in conjunction with this Agreement.

2. **Cost of Services.** Provider's rate for a Psychiatric Initial Evaluation is $250-$300 for 60 minutes visit/therapy session, Psychiatric Follow-up Visit is $155-$199 for 30 minutes session visit/therapy, Individual therapy is $120-$200 for 60 minutes session/therapy, and $50 for CNS VS testing.

3. **Services.** You agree to receive Mental Health Services (the "Services") [which may involve the use of video, audio, SMS, and voice call communications. You understand the risks, benefits, and alternatives of receiving these Services and have had the opportunity to ask questions.

4. **Payment Methods.** You understand and agree that payment for services shall be made prior to or at the time of service using Alma's billing platform or Headway Billing Platform or Elavon Billing platform or Square payment platform. SG Integrative Psychiatry and Wellness accepts payment in the form of credit card or bank card or HSA card. If you will be using insurance to cover some or all of the cost of your appointment, you should call Provider ahead of your appointment to ensure your insurance is accepted and bring your insurance card with you to your appointment or upload your insurance card via an attachment in the MYIO patient portal if the appointment is Telehealth. You should be prepared to pay any co-payments at the time of the appointment with either credit card or bank card or HSA card. If Provider is out of network for your insurance, Provider will submit an out-of-network claim on your behalf, but you must be prepared to pay in full for your appointment at the time of service, with either credit card or bank card or HSA card.

5. **Cancellation Policy.** You understand that your appointment must be canceled at least [forty-eight (48)] hours in advance or you will be responsible for full payment for the missed visit which is $60.

6. **Confidentiality and Compliance.** The provider will take appropriate precautions to keep your health information confidential and to not disclose it without your consent. You are also protected under the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) and any other applicable federal and state laws related to protection of patient information, including but not limited to Public Health Law § 18. There are certain exceptions to when your confidential information would not be protected—for instance, if Provider believes that you will harm yourself or another person or are neglecting or abusing a child or a vulnerable adult.

7. **Waiver of Liability.** By signing this Agreement, you agree to waive, release and discharge Provider from any and all liability, including, without limitation, any injuries that may occur during the provision of services under this Agreement.

8. **Disability Paperwork.** Appointments are not scheduled solely for disability paperwork and each clinician reserves the right for refusal for completion of disability paperwork if it is not deemed a medical necessity.

Acknowledgement and Agreement

I, _____, have read and understand the information provided above, and understand and agree to the terms in this Agreement, including costs of Services, payment methods and cancellation policy. Any questions I had have been answered.

Patient's Name (Print): _____

Patient's Signature: _____

Date: _____

Parent/Guardian Name (if applicable, Print): _____

Parent/Guardian Signature (if applicable): _____

Date: _____