Gladstone
Psychiatry and Wellness

Patient Care and Financial Responsibility Agreement

1. **CONSENT TO MEDICAL CARE:**
By my signature or electronic signature below, I voluntarily consent that I (or my child) will participate in a mental health evaluation and treatment by clinical staff at Gladstone Psychiatry & Wellness, LLC. I understand that the practice of psychiatry is not an exact science, and that there are risks and benefits associated with receiving psychiatric treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the mental health evaluation and treatment rendered to me (or my child) by the clinical staff at Gladstone Psychiatry & Wellness, LLC. Please review the **Detailed Explanation of Consent for Psychiatric Evaluation and Treatment** document on pages 5-6 of this document for further details.

2. **AUTHORIZATION OF TREATMENT FOR CHILDREN AGE 15 AND UNDER:**
According to Maryland State Law, minor patients who are age 15 or under cannot legally consent to their own mental health evaluation and treatment. Evaluation and treatment of minors age 15 and under can only be approved by a biological parent or legal guardian. The consenting parent or guardian must legally possess medical decision-making rights for the minor patient. All parents or legal guardians who legally possess medical decision-making rights for the minor patient must sign the "Parental Consent to Treatment for Patients Age 15 and Under."

   If the legally approved consenting adult(s) cannot attend the minor patient's appointment, or another supervising individual will be present in the place of the legally approved consenting adult, please be aware that this individual does not have legal authority to provide "consent to treatment" for the minor patient. This includes, but is not limited to, step-parents, siblings, grandparents, aunts and uncles, God parents, and/or anyone else who does not legally possess medical decision-making rights for the minor patient regardless of physical custody. A SIGNED LETTER OF AUTHORIZATION OR WRITTEN PRE-AUTHORIZATION must be given to Gladstone Psychiatry & Wellness naming the person(s) you approve to consent to the minor patient's evaluation and treatment on your behalf before services are rendered.

   Minor patients who are age 16 or older may consent to their own mental health evaluation and treatment according to Maryland State Law; therefore, consent from a parent or legal guardian is not needed for a minor patient age 16 and older in order for them to receive mental health services from Gladstone Psychiatry & Wellness, LLC.

3. **RELEASE OF MEDICAL RECORD INFORMATION:**
I hereby authorize Gladstone Psychiatry & Wellness, LLC to disclose all or any part of the contents of the registered patient associated with this form's medical record to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits or otherwise may not serve my interests. Please review the document **Consent to Bill and Release Medical Information to Insurance Company** on page 7 of this document for further details.

4. **PRIVACY POLICY ACKNOWLEDGEMENT:**
I acknowledge that I have received a copy of the Privacy Practices and Patient Rights for Gladstone Psychiatry & Wellness, LLC. I understand that this consent includes my agreement that Gladstone Psychiatry & Wellness, LLC can use private health information for my treatment and the billing of my treatment as defined in the Privacy Practices and Patient Rights. Please review the document **Notice of Privacy Practices & Patient Rights** on pages 3-4 of this document for further details.

5. **ASSIGNMENT OF INSURANCE BENEFITS:**
I hereby request and authorize that any and all insurance benefits due and payable for medical and psychiatric services and rendered to me are to be paid directly to Gladstone Psychiatry & Wellness, LLC. Please review the document **Consent to Bill and Release Medical Information to Insurance Company** on page 7 of this document for further details.

6. **FINANCIAL AGREEMENT AND GUARANTEE:**
I accept full and complete financial responsibility for all charges due to Gladstone Psychiatry & Wellness, LLC for medical and psychiatric services rendered to me. I agree to pay any and all charges that are not covered by insurance including insurance copayments, deductibles, and co-insurance that may be required under the terms of the registered patient's medical insurance policies. This includes any medical care that is considered a "non-covered" service under the terms of the patient's insurance

plan. This is the policy of the patient's insurance company, with which Gladstone Psychiatry & Wellness, LLC is required to comply. Please review and complete the separate document sent titled **Telemedicine Payment Agreement Consent to Bill Credit Card**

a. **PAYMENT AND FEES ARE DUE WHEN SERVICES ARE RENDERED:**
I accept that all estimated charges must be paid at the time of each appointment, before services are rendered.

b. **CHARGES FOR COLLECTION SERVICES**
I further acknowledge, understand, and agree, that in the event of failure to make any payments, in accordance with a payment plan or in the event of default of my financial obligation to pay for services rendered, Gladstone Psychiatry & Wellness, LLC may terminate the "doctor-patient" relationship with the patient and provide them with information to seek care with another provider outside of our practice. Furthermore, in the event of my default of my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs.

c. **LATE CANCELLATION AND NO-SHOW CHARGES:**
As a courtesy to both your provider and all of our patients, we ask that you cancel any scheduled appointments at least 24 hours in advance, so that others may utilize this time. Failure to attend an appointment without cancellation at least 24 hours in advance is considered a "late cancellation." Failure to attend an appointment without any cancellation or notice is considered a "no-show." Patients will be charged a $75 fee for both a no-show and/or late cancellations. The $75 fee will be charged per missed visit. Patients with frequent no-show appointments will be asked to complete a treatment plan for continuing care with their clinician and are subject to termination of care at our practice.

7. **MISSED OR CANCELLED APPOINTMENTS:**
Office and/or telemedicine visits are by appointment only. All administrative and billing matters, including copayment and completion of any forms, are expected to be completed before the time of your appointment. Patients are asked to arrive 15 minutes before the scheduled appointment time in order to complete the check-in process. Patients arriving more than 20 minutes late may be required to reschedule their appointment for the next available opening consistent with the type of appointment requested.

Please look carefully over pages 4-11 of this document, then initial each statement.

I, the undersigned, agree that I:

_____ have reviewed and agree with the **Notice of Privacy Practices & Patient Rights** (pages 4-5)
_____ have reviewed and agree with the **Detailed Explanation of Consent for Psychiatric Evaluation and Treatment** (pages 6-7)
_____ have reviewed and agree with the **Consent to Bill and Release Medical Information to Insurance Company** (page 8)
_____ have reviewed and agree with the **Telemedicine & Online Counseling Agreement** (pages 9-10)
_____ have reviewed and agree with the **Consent for Telephone, Email and SMS Text Messaging** (page 11)

I, the undersigned, herby certify that I have provided correct information about the patient during registration. I understand that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. I certify that I have read, fully understand, and accept the above information, terms, and conditions. I, the undersigned, further certify that I am legally authorized as the patient, or as the patient's parent or legal guardian, to execute the above and to accept its terms.

_____ _____
PATIENT NAME OR **NAME OF PARENT/ LEGAL GUARDIAN** (PRINTED) **DATE**

_____ _____
PATIENT SIGNATURE OR **PARENT/ LEGAL GUARDIAN SIGNATURE** **DATE**

_____ _____
PATIENT PREFERRED NAME **PATIENT DATE OF BIRTH**

Gladstone
Psychiatry and Wellness

Parental Consent to Treatment for <u>Patients Age 15 and Under</u>

At Gladstone, we understand that families come in all different shapes and sizes. In order to provide your family with the best care, we must verify that we have the correct consent to treatment.

Please check the appropriate box below and follow associated instructions to consent for treatment of patients age 15 and under *(the state of Maryland permits minors to consent to their own mental health treatment at the age of 16*):

- ☐ **Biological Parents are Married:** Only one parent's signature is required.
- ☐ **Separated/ Divorced- One Parent Has Sole Legal and/or Medical Decision-Making Rights:** If one parent has sole legal and/or medical decision-making rights for the patient, then *only that parent's signature is required.*
- ☐ **Separated/ Divorced- Both Parents Have Joint Legal and/or Medical Decision-Making Rights:** If parents are separated or divorced and have joint legal and/or medical decision-making rights for the patient, then *BOTH parents' signatures are required* before patient can receive treatment. (See below) ***
- ☐ **Legal Guardian/ Non-Biological Parent:** *Only the legal guardian's signature is required* for treatment.

Please send any associated documentation to our office prior to the patient's intake appointment.

AUTHORIZATION:

I (parent/legal guardian) request and authorize Gladstone Psychiatry and Wellness to deliver psychiatric treatment to my minor child as may be deemed necessary or advisable in the diagnosis and treatment of my minor child.

I have the legal right to authorize Gladstone Psychiatry and Wellness to deliver psychiatric treatment and therapy to my child. I have read, understand, and give my consent as stipulated above. I understand that my signature means that I have read this form and/or have had it read to me and explained in language that I can understand.

_____
Signature of Parent or Legal Guardian

_____/ _____
Printed Name / Date

_____
Relationship to Patient

***__If you selected the option "Separated/ Divorced- Both Parents Have Joint Legal and/or Medical Decision-Making Rights__:" You must contact the office and request an additional minor consent form to be sent to the other parent/medical decision-maker. Any person under age 16 cannot be prescribed medicine without <u>all legal guardians consenting to treatment</u>. If this form is not signed by both parents at time of appointment, no medications will be prescribed. ***

Gladstone
Psychiatry and Wellness

Notice of Privacy Practices & Patient Rights

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 and direct any questions to your provider or other Gladstone staff.**

Your Rights
You have the right to:

- **Obtain a copy of your paper or electronic medical record**
  - You can ask to view or receive an electronic or paper copy of your medical record. Please ask the office manager for more information.
  - We will provide a copy or summary of your health information within 30 days of your request. We may charge a reasonable, cost-based fee, depending on the size and nature of the request.
- **Update and/or correct your paper or electronic medical record (this does not pertain to clinical impressions)**
  - You can ask us to update and/or correct health information that you believe is incorrect or incomplete (this does not pertain to clinical impressions). Please discuss this with your provider.
  - We reserve the right to deny these changes, in which case you may ask for a written explanation of the reason your request was denied. We have 60 days to comply.
- **Request confidential communication**
  - You can ask us to contact you, or not contact you, using a specific form of communication (for example, telephone or email) or to send mail to a different address.
  - We will do our best to meet all reasonable requests.
- **Ask us to limit the information we share or use**
  - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to meet your request, and we may deny your request if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, without assistance from your insurance provider, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. We will comply with all reasonable requests unless a law requires us to share that information.
- **Obtain a list of those with whom we have shared your information**
- **Obtain 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 on your behalf**
  - If you have given someone medical power of attorney or if someone has legal guardianship over you, that person may exercise your rights and make choices about your health information.
  - We will verify this person's authority to the best of our ability before we take any action.
- **File a complaint if you believe your privacy rights have been violated**
  - You can issue a complaint if you feel Gladstone Psychiatry & Wellness has violated your rights. To do so, please speak with the officer manager and/or ask to be contacted by the Chief Clinical Officer. You can call 443-708-5856 to reach our phone directory.
  - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights via letter, telephone or online.
    - Address: 200 Independence Avenue, S.W., Washington, DC, 20201
    - Phone Number: 1-877-696-6775
    - Website: www.hhs.gov/ocr/privacy/hipaa/complaints/.
  - We will not retaliate against you for exercising your rights and filing a complaint.

Your Choices
You have some choices in the way we use and share your information as we:

- **Communicate with family and other significant parties about your treatment**
- **Coordinate care**
- **Provide disaster relief**
- **Provide mental health care**

We will ask for your permission before sharing your health information with others outside of Gladstone Psychiatry & Wellness unless required by law.

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

- **Provide clinical care and treatment for you at Gladstone Psychiatry & Wellness**
  - We can use and share your health information with clinicians at Gladstone Psychiatry & Wellness, and other professionals who are involved in your treatment, for the purpose of providing you with the highest quality care.

- **Maintain organizational functioning**
    - We can use and share your health information to maintain organizational functioning of Gladstone Psychiatry & Wellness, improve your care, and contact you when necessary.
- **Bill you and your insurance provider for services**
    - We can use and share your health information to bill and receive payment from your health insurance provider or other entities.
- **Assist with public health and safety issues**
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - **Child abuse reporting:** If there is a reason to suspect that a child (anyone under the age of 18) is or was abused or neglected, ***Maryland law requires reporting the matter immediately and providing relevant information to the Department of Social Services in the county/location where the abuse occurred.*** Emergency services may be contacted if the child is believed to be in immediate danger.
    - **Adult abuse reporting:** If there is reason to suspect an elderly or incapacitated adult is abused, neglected or exploited, ***Maryland law requires reporting the matter and providing relevant information to the Department of Welfare or Social Services where the person currently resides.*** Emergency services may be contacted if the person is believed to be in immediate danger.
    - **Preventing or reducing a serious threat to anyone's health or safety:** Under Maryland law, if you communicate to your clinician a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person or yourself, and they believe you have the intent and ability to carry out that threat immediately or imminently, they are legally required to take steps to protect you and third parties. **These precautions may include (1)** warning the potential victim(s), or the parent or legal guardian of the potential victim(s), if under the age of 18, **(2)** notifying law enforcement and/or other emergency services, or (**3)** seeking your hospitalization.
- **Comply with the law**
    - We will share your health information as required by state or federal laws, including with the Department of Health and Human Services in order to show Gladstone Psychiatry & Wellness' compliance with federal privacy laws.
- **Address worker's compensation, law enforcement, and other government requests**
    - This may include, but is not limited to, law enforcement purposes, health oversight agencies for activities authorized by law, and special government functions (i.e. military, national security, and presidential protective services).
- **Respond to lawsuits and legal actions**
    - We will share health information about you in response to a court or administrative order, or in response to a subpoena. We will do our best to discuss with you any orders received before we carry out such orders.

What Other Ways 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 must meet many conditions in the law before we can share your information for these purposes. Please visit the following website for more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumders/index.html.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will promptly let you know if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and provide you with a copy.
- We will not use or share your information other than as described in this notice unless you give permission. You may retract your permission at any time. Please provide any retraction of permission to share your health information in writing.

Changes to the Terms of this Notice
Gladstone Psychiatry & Wellness may change the terms of this notice at any time. Any changes to this notice are available upon request.

Gladstone
Psychiatry and Wellness

Detailed Explanation of Consent for Psychiatric Evaluation and Treatment

Gladstone Psychiatry and Wellness will only provide treatment to those to consent for this service. The below is an expanded explanation of the Consent to Medical Care described on page one.

1. **I voluntarily consent to participate (or allow my child to participate) in a mental health evaluation and subsequent treatment** (*as deemed medically appropriate and necessary*) **conducted by clinical staff at Gladstone Psychiatry & Wellness, LLC.** I understand that following the evaluation and/or treatment, information will be provided to me concerning each of the following areas:
    a. The benefits of the proposed treatment;
    b. Alternative treatment modes and services available;
    c. The manner in which treatment will be administered;
    d. Potential side effects from treatment and/or risks of side effects from medications (when applicable);
    e. Probable consequences of not receiving treatment.

The evaluation and treatment will be conducted by a licensed Psychiatrist, Nurse Practitioner, Social Worker or Therapist. Treatment will be conducted within the boundaries of Maryland State Law.

2. Benefits of Psychiatric Evaluation and Treatment:

Evaluation and treatment may be conducted by psychiatric and psychological interviews, psychological assessment or testing, psychotherapeutic interventions and medication management. It may be beneficial to me, as well as any referring professional, to understand the nature and cause of any difficulties affecting daily functioning, so that appropriate recommendations and treatments may be offered. Uses of the evaluation include, but are not limited to, diagnosis, evaluation of recovery or treatment, estimating prognosis, education and rehabilitation planning. Possible benefits of treatment include: Improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. Charges:

Fees are based on the length or type of evaluation or treatment, which are determined by the nature of the service deemed appropriate and/or necessary by clinical staff at Gladstone Psychiatry & Wellness. I agree to be responsible for any charges not covered by insurance, including deductibles, co-insurance, copayments, late cancellation fees, no-show fees, and fees related to administrative services, such as the completion of disability evaluations, unemployment forms, and copying medical records.

***Please Note:** The request for administrative services and the completion of clinical paperwork (copying medical records/documents, unemployment forms, disability evaluations, school forms, etc.) may take 7-10 business days to be completed depending on the nature of the request. A cost-based fee will be associated with these requests depending on the size and nature of the service.

4. Confidentiality, Harm and Inquiry:

Information from my (or my child's) evaluation and treatment is contained in a confidential medical record at Gladstone Psychiatry & Wellness, LLC. I consent to disclosure and use of this information by Gladstone Psychiatry & Wellness, LLC for the purpose of continuity of care. In accordance with Gladstone Psychiatry & Wellness' Privacy Practices and Patient Rights, and Maryland State Law, all patient information will be kept confidential with certain exceptions, including, without limitation, the following:

a. The patient presents an imminent danger to self or others.
b. There are reasonable concerns of abuse or neglect of a child or vulnerable adult.
c. A court order or subpoena is issued.

5. Right to Withdraw Consent:

I have the right to withdraw my consent for evaluation and treatment (for myself or my child) at any time by providing a written request to Gladstone Psychiatry & Wellness, LLC.

- I voluntarily consent to participate in (or allow my child to participate in) evaluation and subsequent treatment as deemed medically appropriate and necessary by clinical staff at Gladstone Psychiatry & Wellness, LLC.
- I attest that I have the right to consent to evaluation and treatment (for myself or my child).

- I will complete the associated Parental Consent for Treatment if I am consenting to the evaluation and treatment of a minor under the age of 16.
- I have read this form in its entirety or had this form read/explained to me in its entirety.
- I fully understand its contents, including the potential risks and associated benefits of participating in psychiatric evaluation and treatment.
- I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I have the right to ask questions about the above information at any time.
- I understand that I have the right to withdraw my consent for evaluation and treatment (for myself or my child) at any time and I understand how to do so.

Gladstone
Psychiatry and Wellness

Consent to Bill and Release Medical Information to Insurance Company

I herby authorize Gladstone Psychiatry & Wellness, LLC to submit claims to my insurance company. I hereby request and authorize that payment of medical benefits be paid directly to Gladstone Psychiatry & wellness, LLC for services provided.

I herby accept full and complete financial responsibility for all charges due for medical services rendered to me. I agree to pay any and all charges that are not covered by my insurance company, including insurance copayments, deductibles, and co-insurance, that may be required under the terms of my medical insurance policies. I agree to pay any and all charges that are considered a “non-covered” service under the terms of my medical insurance plan.

I herby authorize Gladstone Psychiatry & Wellness, LLC to disclose all or any part of the medical record of the patient named on this consent to my insurance company consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve my interests.

Gladstone
Psychiatry and Wellness

Telemedicine & Online Counseling Agreement

Telemedicine and online counseling are useful supplements to in person mental health treatment services for some patients. Many patients find it convenient and easy to access. This is best used in conjuncture with in-person mental health treatment services. The following document outlines the potential limitations and risk associated with Telemedicine and online counseling.

Licensing and State Requirements

States vary on the laws around telemedicine and online counseling. It is the patient's duty to inform the clinician if they travel out of the state that they presented at the time of intake. The clinician will inform the patient if they are able to provide the service in the state they are located.

*I agree to inform the counselor if I am no longer in the state presented at time of intake

Confidentiality

For telemedicine and online counseling sessions, service is delivered using a secure site such as through the electronic medical record system (Valant) or Zoom. The patient is provided with instructions and a link in order to login. Other means of communication, such as the telephone, may be used if agreed upon by both the clinician and the patient.

There are potential risks to confidentiality when using telemedicine and online counseling, such as data hacks, password protection, forgetting to log off, a patient using their device within public views, and information being sent to the wrong parties. Telemedicine and online counseling require both the patient and the clinician to mutually ensure that all reasonable precautions are taken to prevent accident breaches of confidentiality. In addition, clinician and patients agree not to record sessions.

Duty to Warn: As in face to face interactions, a clinician may have to break confidentiality if an individual is going to hurt themselves, someone else, or if someone is hurting them. This is the same for telemedicine and online counseling. In order to ensure the safety of the patient, the clinician requires an up to date address, photo ID, and emergency contact information. During the intake, the clinician and patient will develop a safety plan in case of an emergency. It is important that if any information changes, the clinician and/or Gladstone Psychiatry & Wellness is informed immediately.

*I understand the limits of confidentiality as outlined above

*I agree to provide my current address and emergency contact information

*I agree to inform the clinician and/or Gladstone Psychiatry & Wellness of any updates to this information immediately

Terminating Telemedicine and Online Counseling

While telemedicine and online counseling can be helpful for many, some people struggle because it limits the ability for both the clinician and the patient to read each other's body language and nonverbal communication. Patients may also need different levels of care at different times during their treatment journey.

At any time, if the clinician believes that online treatment is not meeting the needs of the patient, they may terminate online treatment. The patient may also decide that this modality of treatment is not meeting their needs. If this occurs, the patient and clinician will discuss a treatment plan and options in order to preserve a continuation of care, and to ensure that the patient's needs are being addressed.

*I agree to the termination guidelines as outlined above

Limitations of Telemedicine and Online Counseling

Telemedicine and online counseling are not appropriate for all patient needs. It is not recommended for persons who are currently experiencing the following: active self-harm ideation, suicidal ideation, and homicidal ideation. As well as, persons who are currently experiencing psychiatric symptoms such psychosis, severe depressive episodes, or active addictions. It is not appropriate for those in crisis situations or those experiencing abuse. It is not appropriate for those undergoing trauma treatments. If the person is under 16 years of age, appropriateness will be discussed with the parent. Some exceptions may be made if it is only occasional and/or supplemental to in-person treatment. Exceptions may also be made in a crisis or emergency situation where medical necessity outweighs the limits/risks of telemedicine and online counseling mentioned above.

* I understand the limitations mentioned above and agree to discuss any issues that may exclude me from telemedicine and online counseling with my clinician

*I understand that it is my responsibility to obtain and report vital signs (blood pressure, heart rate, height, and weight, etc.) to my provider upon request for the purpose of medication management

Fees and Insurance

The billing department of Gladstone Psychiatry & Wellness will assist in checking the patient's insurance coverage and benefits; however, the patient is responsible for verifying that their policy covers the treatment provided and understanding any financial responsibility for which they may be liable beyond the restrictions of their policy. All applicable fees, such as coinsurance, co-payments, and deductibles are the responsibility of the patient and due before the time of service.

A $75.00 short-notice cancellation/re-schedule fee will be charged directly to the patient if the telemedicine or online counseling appointment is not cancelled within 24 hours of the scheduled appointment time. A $75.00 no-show fee will be charged directly to the patient if the patient fails to participate in the scheduled telemedicine or online counseling appointment.

There is a risk of loss of service or troubles with connectivity when participating in telemedicine or online counseling. No fee will be charged to the patient if this occurs at the fault of Gladstone Psychiatry & Wellness.

*I agree to verify that my insurance policy covers the treatment provided

*I agree to pay any financial responsibility which my insurance does not cover, including, but not limited to, all missed session/no-show fees, late cancellation fees, co-pays, and coinsurance

Gladstone
Psychiatry and Wellness

Consent for Telephone, Email and SMS Text Messaging

I authorize my clinician and other staff at Gladstone Psychiatry and Wellness to communicate with me via the following communication methods:

- **Email**
- **Telephone**
- **Standard SMS Text Messaging**

I hereby consent to have my clinician and other staff at Gladstone Psychiatry and Wellness communicate with me outside of the protected patient portal (Valant) by email, telephone, or standard SMS text messaging, as specifically indicated above, regarding various aspects of my medical care. This may include, but is not limited to, scheduling, appointment, billing, mental health treatment, and other private, protected, and confidential health information.

I understand that Gladstone will make every effort to limit the amount of protected health information shared outside of the patient portal (Valant), and to ensure my privacy and confidentiality as best as possible; however, I understand that email, telephone and standard SMS text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email, telephone and standard SMS text messaging regarding my medical care might be intercepted and read by a third party.