



***This Consent is for patients or the parent/guardian/managing conservator of minor child patients of (Avenues Unlimited).***

Avenue Unlimited is currently staffed by Jacqueline Browning, MSN, APRN, PMHNP-BC serving as the Psychiatric Mental Health Provider. Jacqueline is a Psychiatric Mental Health Nurse Practitioner – Board Certified (PMHNPBC). An PMHNP-BC is an advanced practice registered nurse (APRN) who has received advanced education and training in providing a wide range of psychiatric and mental healthcare services to patients and families in a variety of settings. PMHNP-BC's diagnose, conduct therapy, and prescribe medications for patients who have psychiatric disorders, medical organic brain disorders, or substance abuse problems. They are licensed to provide emergency psychiatric services, psychosocial and physical assessment of their patients, treatment plans, and manage patient care.

**Informed Consent.** I understand I have the right to make an informed decision about treatment. My provider has explained the treatment plan to me. I understand this is an outpatient level of care.

**Patient's Rights.** Patients have the right to make an informed decision about their own treatment.

**Providing Accurate Medical Information and Diagnostic Testing**

\* Patient agrees to be truthful about medical information, diagnoses and medications, etc., agrees to provide medical records if requested by provider and agrees to any diagnostic testing that may be required in the prescribing and maintenance of medications if applicable. Patient is responsible for cost occurred by any diagnostic testing.

**Voluntary, Informed Consent to Treatment.** My signature below indicates voluntary consent for the treatment plan for myself or the minor child.

**\* If for a minor child, I hereby attest I am the legal guardian of the minor child and have the right to consent to treatment for this child.**

This consent applies to all providers at Avenues Unlimited who may provide services and permits the sharing of information among Avenues Unlimited staff.



**Duration of Consent.** I understand that consent expires after 12 months and I have the right to withdraw this consent in writing at any time. I understand this consent is for treatment and does not include participation in research.

**Fees and Insurance.** This is a private pay practice and Avenues Unlimited does not process insurance claims.

The fee for a Initial Psychiatric Evaluation is

\$300.00 (60 minute) for 18 years of age and older

\$375.00 (90 minute) for under 17 years of age and younger,

\$150.00 (60 min) follow up visits (psychotherapy and medication management)

\$125.00 (30 min) medication management only

\$50.00 (30 min) paper work session *\*Existing patients who need FMLA or Short/Long-term disability paperwork filled out completed will work with administrative staff member to discuss needs, expectations, timelines, etc. Please bring a hard copy of your paperwork to this appointment. Please be aware that after your appointment, it may take one week to fill out, process, and send your paperwork.*

You acknowledge and agree that you are fully responsible for the charges and expect them to be applied to your account. If you choose to use your insurance, you understand that certain information about your case will be shared with your insurance company and or an intermediary for purposes of filing the claim.

By consenting to treatment, you acknowledge that you are responsible for the cost of services provided to you or your minor child and agree to pay them when billed or at time of service. If services are not paid you agree to pay a service charge and or any finance charge that may apply. After 90 days your account may be assigned to an outside collection agency in which case you will be responsible for paying attorney and or collection fees and expenses. There will be a charge of \$25.00 after 90 days for collection fees. A 24-business hour notice is required for cancellation of an appointment. The fee for a missed initial appointment without the 24-business hour notification is \$150.00 and for a follow up appointment is \$75.00.

**Medication Refill/Prior Authorization Policy.**

There is a \$25.00 charge for each prior authorization that our office is required to obtain and for any prescription you need filled outside of your office time. This fee is required to be paid before the service is rendered.

**Medication request are only addressed during business hours.**



**Returned Checks.** There will be a fee of \$50 for returned checks.

Medical Records. If you need to request your medical records, you must provide a signed notification and give a two-week notice.

There will be a charge of \$25.00. Forms, Letter Request. In the event you need us to provide any forms or letters on your behalf there will be a fee ranging between \$100.00 and \$300.00 based on time and complexity.

You will be responsible to pay at the time of request.

**Legal Actions/Court Appearance.**

If legal action occurs in which your provider is requested or subpoenaed to provide testimony you will be responsible for the following even if the subpoena is sent from the opposing side of the case: A) Travel Expenses B) Hourly or per diem fees based on our current fees from the time the provider leaves the office until she returns. C) A minimum of fifty percent of the cost will be required prior to the court appearance. D) Record copying will be \$25.00 E) Provider Fee is \$350.00 per hour (minimum 6 hours will be billed).

**Emergency Care.**

In case of an emergency, I understand Jacqueline Browning & Avenues Unlimited reserves the right to administer medical treatment on the premises or to contact and advise emergency personnel on the premises or at an emergency room regarding my needs at that time.

**Danger.**

In the event your provider in her clinical judgement believes you to be a danger to yourself or others, by signing this consent, you authorize her to contact your listed emergency contact or someone else to help provide assistance through this crisis situation. I acknowledge that if I have an emergency I should dial 911 and or present to the nearest emergency room.

**Indemnification.**

I will indemnify and hold harmless from any expense or claim of any nature any person or entity that provides or causes to be provided examination, treatment, or hospital care under this authorization (except to the extent such person or entity is negligent therein) and conditionally agree to make or cause to be made, by assignment of third-party benefits or otherwise, full and complete payment for such examination, treatment, or hospital care.



### **Limits to Confidentiality.**

The information I give in treatment is generally confidential and will only be released outside of Avenues Unlimited with my written permission (or with the permission of a parent or guardian of a minor). However, I acknowledge these limits to confidentiality under Kentucky and federal statutes: (i) Jacqueline Browning may use information within Avenues Unlimited and with its business associates for treatment, payment, and other healthcare operations. (ii) Jacqueline Browning will consult with physicians in order to provide a high quality of care, to answer certain subpoenas or court orders, to report threats of homicide or suicide, to report the suspicion of child abuse or child neglect, and may report elder abuse or abuse of a handicapped person or crime which may occur in the future. (iii) Jacqueline Browning may report physical assaults or crimes which occur on the site of appointment. (iv) Jacqueline Browning may report prenatal exposure to controlled substances.

### **Limited Disclosures.**

All disclosures will be made to the appropriate parties as directed by law, such as authorities, parents of minors, or intended victims of violence. When Jacqueline Browning must release information without your consent, the information revealed will be limited to what is necessary to protect you or to protect others, or the limited information necessary for collection of a past due bill, or the information ordered to be released to the court. When information is released with your consent, we will release the information you request us to disclose.

### **Termination of Services.**

I understand and agree that I am entering into a therapeutic relationship with my provider. The success of the treatment is contingent upon active participation and continual attendance. More than three no shows will result in termination of services. Your file will be closed after sixty days of zero communication and no appointment.

### **Acknowledgement.**

I hereby acknowledge that I received an explanation of this consent, the limits of confidentiality, the proposed treatment plan, and the payment plan. I received a copy of the information in this form, Avenues Unlimited HIPAA Privacy Notice. I have read the above, and hereby consent to the services of the PMHNP-BC for my (or the minor child's) mental healthcare needs, in the outpatient setting. I understand that my provider, Jacqueline Browning may make a recommendation for inpatient level of care or any other level of care as provider deems beneficial for patient safety. I understand that if I have an emergency, I need to call 911 or present to the nearest emergency room.



Print Name of Patient: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*If Patient is a Minor Child, please complete and sign below.

Print Name of Minor Child Patient: \_\_\_\_\_

Minor Child's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name of Parent/Guardian/Managing Conservator: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian/Managing Conservator