CONSENT TO TREATMENT, PRIVACY, FINANCIAL RESPONSIBILITY, AND RECORDS ACKNOWLEDGMENT

Patient Name: _____

Responsible Party: _____

Patient DOB: _____

Relationship: _____

DOB: _____

CONSENT

RESPONSIBLE PARTY

SS#: _____ - _____- _____

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This field is **REQUIRED** in the event you or your child's financial obligation is not met by our financial agreement. Triad will make all reasonable efforts to bill your assigned insurance carrier. But if contracted payment cannot be recovered from your insurance carrier, as a last resort, we will initiate collections activity only after exhausting all other means, including requesting payment from the responsible party.
Please initial here. _____

If services are for a minor, do you have medical decision-making authority?
Yes: _____ No: _____
Please initial here. _____

If "NO" to the above statement, who has medical decision-making authority? _____
If the patient is a minor, I certify that I have legal authority to consent to treatment. I agree to provide custody, guardianship, parenting plan, or court documentation upon request and to notify Triad Psych, PC

immediately of any change affecting decision-making authority, custody, guardianship, or access to records.
Please initial here. _____

CONFIDENTIALITY

Information regarding your treatment will not be released without written authorization except when disclosure is required or permitted by law. Confidentiality may be limited in situations including, but not limited to, clear and immediate danger to self or others, serious and imminent risk of harm, suspected abuse, neglect, or exploitation of a child, suspected abuse, neglect, or exploitation of a disabled adult or elder person, medical emergencies, court orders, subpoenas, legal proceedings, insurance/payment activities, quality review, or other circumstances required or permitted by federal or Georgia law.

If Triad Psych, PC determines that a disclosure is required by law or necessary to reduce a serious and imminent threat, the disclosure will be limited to the information reasonably necessary for the disclosure when appropriate and consistent with applicable law.

Mandated reporting may include reports to the Georgia Division of Family and Children Services, Adult Protective Services, law enforcement, or another legally designated agency, depending on the facts and the applicable reporting law.
Please initial here. _____

CONSENT FOR TREATMENT, USE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for Triad Psych to use and disclose Protected Health Information (PHI) about me or my child to perform treatment, payment, and healthcare operations (TPO). I have the right to review with my clinician Triad's privacy practices and modify them in agreement with Triad management. With this consent, Triad Psych may call my home, cell phone, or other alternative location and leave a message with a person or voicemail in reference to any items that assist the practice in administering TPO, such as appointment reminders, insurance items, and any calls about me or my child's clinical care, including test results, etc.

With this consent, Triad Psych may use unencrypted e-mail to my home or other alternative location for any items which assist the practice in administering TPO, such as appointment reminders and statements. I have the right to request that Triad Psych restrict how it uses or discloses my PHI to administer TPO. However, the clinic is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. With my signature, I am consenting to Triad Psych using and disclosing my PHI to administer TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Triad Psych may decline to provide treatment for me or my child.

I understand that communications may include limited information necessary to identify Triad Psych, PC, appointment information, billing information, insurance information, and other administrative or care-related details. I understand that I may request reasonable communication restrictions in writing, and if Triad Psych, PC agrees to a restriction, the practice will follow the agreed restriction except where disclosure is required or permitted by law.
Please initial here. _____

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been offered and/or received Triad Psych, PC's Notice of Privacy Practices, which describes how my protected health information may be used and disclosed and explains my rights regarding that information. I understand that I may request a copy of the Notice of Privacy Practices at any time.

I understand that I may request restrictions on certain uses or disclosures of my PHI, request confidential communications, request access to my records, request amendment of my records, and request an accounting of certain disclosures as explained in the Notice of Privacy Practices. I understand that some requests may be subject to legal limitations, verification requirements, fees, or clinical/legal review.
Please initial here. _____

TRIAD PSYCH, P.C.
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PSYCHOTHERAPY NOTES AND CLINICAL RECORDS

I understand that progress notes and other required clinical documentation are part of the clinical record and may be used or disclosed for treatment, payment, and health care operations as permitted by HIPAA and applicable law. Psychotherapy notes, if maintained separately by my clinician, receive additional privacy protections under HIPAA and generally require a separate written authorization for use or disclosure, except where permitted or required by law.
Please initial here. _____

ELECTRONIC COMMUNICATION CONSENT

I understand that email, text messaging, voicemail, patient-portal messages, and other electronic communications may not be fully secure and may carry privacy risks. I authorize Triad Psych, PC and its authorized vendors to communicate with me using the contact methods I provide for scheduling, billing, insurance, administrative, and clinical-care coordination purposes unless I submit written restrictions. I understand that electronic communication is not appropriate for emergencies or urgent clinical needs.
Please initial here. _____

TELEHEALTH CONSENT, IF APPLICABLE

If I participate in telehealth services, I understand that telehealth involves the use of electronic communications and may carry privacy, security, technical, and clinical limitations. I agree to provide my physical location at the start of each telehealth session and to identify an emergency contact when requested. I understand that technology failures may interrupt services and that my clinician may recommend in-person services, emergency care, or other treatment options when clinically appropriate.

For telehealth services, I understand that the provider must be appropriately licensed or otherwise authorized to provide services to the patient in the location where the patient is physically located at the time of service. I understand that telehealth must meet the same legal, ethical, confidentiality, documentation, and standard-of-care requirements that apply to in-person services.

I agree to participate in telehealth only from a private and safe location unless otherwise discussed with my clinician. I understand that my clinician may ask to verify my location, emergency contact, and local emergency resources at the start of telehealth services or as clinically necessary.
Please initial here. _____

EMERGENCY AND CRISIS LIMITATION

I understand that Triad Psych, PC is not an emergency crisis service. If my child or I am in immediate danger or experiencing a medical or psychiatric emergency, I should call 911, go to the nearest emergency room, or contact the appropriate crisis resource. I understand that routine office phone, voicemail, email, text, portal, or telehealth communications may not be reviewed immediately.
Please initial here. _____

FINANCIAL POLICY

Payment is expected at the time of service unless there is a prior written agreement for payment. It is the responsibility of the patient/responsible party to verify benefits, eligibility, coverage limitations, deductibles, co-insurance, co-payments, referral requirements, and any required preauthorization or precertification before services are provided. All insurance co-payments, co-insurance amounts, deductibles, and non-covered charges are due at the time of service unless other written arrangements have been made. As a courtesy, Triad Psych, PC or its software vendor may send appointment reminders by text and/or email 24 and 48 hours before an appointment; failure to receive or respond to a reminder does not constitute notice of cancellation.

A full charge of $100.00 for appointments will be made to the patient and/or responsible party if the office is not notified 24 hours in advance regarding cancellation. Missed appointment and late-cancellation fees are the responsibility of the patient/responsible party and are generally not billable to insurance. Dissatisfaction with services does not excuse the obligation to pay for services.

All court/forensic work will be paid for in advance by the party initiating the service. The patient/responsible party will be responsible for all legal and collection fees on balances, including clinician lost time, collection agency fees, a collection fee of $9.95 per claim may be added to cover

administrative costs associated with pursuing unpaid balances, and magistrate court charges if it is handled through those means. Also, letters, IEP/504 documentation, forms, reports, or other services completed outside of scheduled sessions will be subject to an additional fee based on the current rate. I have read and understand this statement.

Therapy records, treatment summaries, subpoenas, attorney contacts, court testimony, custody disputes, forensic services, and legal requests may involve additional clinical, administrative, and legal review. Such matters may affect confidentiality and may require separate written authorization, court order, subpoena response, or prepayment according to the practice's current policies and applicable law.
Please initial here. _____

NO SURPRISES ACT/GOOD FAITH ESTIMATE

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services. Most of the services at Triad Psych are billed to insurance companies. Yet there are certain services provided that are not covered by insurance or are only partially covered by insurance. This includes but is not limited to testing, report writing, filling out forms, etc. In these instances, patients are entitled to a written Good Faith Estimate (GFE) from their clinician. Make sure your therapist gives you a Good Faith Estimate in writing at least one business day before your first appointment.

You can also ask your therapist, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. Triad will also save a copy of your GFE to our software system for reference. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call your chosen therapist.
Please initial here. _____

TERMINATION/FINISHING WELL

How we finish is just as important as how we begin. We'll begin to discuss termination when your goals move toward completion. If you start to think about wrapping up therapy prior to this, bring it up to discuss

in session. We ask that you give a minimum of two sessions' notice, which allows one session for us to explore your or your child's termination readiness and a final session to process the journey, progress, and identify specific "take-aways" from the work you have accomplished.
Please initial here. _____

INSURANCE AND COVERAGE ACKNOWLEDGEMENT

I understand that it is my responsibility to provide accurate and up-to-date insurance information at the time of service and to notify Triad Psych, PC of any changes and/or lapses in my insurance status. I acknowledge that failure to maintain active coverage or communicate changes may result in denied claims, and I agree to be personally responsible for all charges incurred. This includes any charges not covered by insurance, such as uninsured services. I understand that Triad Psych, PC does not guarantee coverage or payment and that it is solely my responsibility—not Triad Psych, PC's—to verify my insurance eligibility before each visit.
Please initial here. _____

SECONDARY INSURANCE ACKNOWLEDGEMENT

Triad Psych, PC does not bill secondary insurance carriers. I understand and acknowledge that it is the sole responsibility of the patient or designated responsible party to submit claims to their secondary insurance provider for any applicable reimbursement. I also understand that it is recommended to contact the secondary insurance provider directly to determine their claim submission requirements and timelines.
Please initial here. _____

GUARANTEE OF PAYMENT

I give my personal guarantee of payment for all charges herein incurred. I attest that all of the above statements are true. I authorize Triad Psych, PC to disclose information reasonably necessary to obtain payment, benefits, authorization, claim review, quality review, audit review, or related insurance processing. I understand that any disclosure beyond what is permitted for treatment, payment, health care operations, or otherwise required or permitted by law may require a separate written authorization.
Please initial here. _____

AI-ASSISTED DOCUMENTATION AND TEMPORARY RECORDING CONSENT

Our clinic has opted to use Blueprint's note-taking system as part of our effort to provide excellent care to clients. Blueprint's note-taker temporarily records sessions and uses this recording to automatically generate a progress note, which is a required form of clinical documentation. After a progress note is generated, the recording is automatically deleted from Blueprint's servers and database. Use of this technology allows your therapist to be fully present during your sessions without having to slow down to take notes or rely on memory after the session.

Blueprint's software is represented as HIPAA-compliant and SOC 2 Type 2 certified, meaning an external third-party auditor reviews Blueprint's systems, policies, and processes on an ongoing annual basis to assess data privacy and security controls. By signing this consent form, I agree to allow my clinician to record sessions temporarily for the purpose of generating clinical documentation. I understand that I may ask questions about this technology before signing and may revoke this consent in writing for future sessions. Revocation will not affect documentation already created before the revocation. I understand that this technology is intended to assist documentation and does not replace my clinician's professional judgment.

I understand that Triad Psych, PC should maintain appropriate agreements and safeguards with any vendor that creates, receives, maintains, or transmits PHI on behalf of the practice, including any required Business Associate Agreement. I understand that recordings or generated notes should not be used for any purpose unrelated to clinical documentation unless separately disclosed and legally authorized.

Signature Patient/Responsible Party: _____

RECORDS REQUESTS AND RETENTION

I understand that requests for records, amendments, releases of information, or copies of records must be submitted according to Triad Psych, PC's policies and applicable law. Record requests may require identity verification, written authorization, clinical review, legal review, and/or applicable copying or

administrative fees. Records will be retained and disposed of according to applicable federal and Georgia requirements and Triad Psych, PC's record-retention policies.

I understand that certain records may be excluded from ordinary access rights or may be subject to special privacy rules, including psychotherapy notes if maintained separately, information compiled for legal proceedings, information restricted by state or federal law, or information that requires clinical, legal, or safety review before release.

Triad Psych, PC should maintain a written record-retention schedule and should apply it consistently to clinical records, billing records, releases, consent forms, Good Faith Estimates, vendor documentation, and related administrative records according to applicable federal and Georgia requirements and professional standards.

SIGNATURE ACKNOWLEDGMENT

By signing below, I acknowledge that I have read and understood this document, have had the opportunity to ask questions, and agree to the terms stated above. I understand that this form is intended to support informed consent, privacy acknowledgment, financial responsibility, and administrative compliance, but it does not replace separate written authorizations, releases, notices, treatment plans, or policies required by law or by Triad Psych, PC.
Date: _____

COMPLIANCE INSIGHT AND PURPOSE OF THIS CONSENT PACKET

This consent packet is intended to support informed consent, clinical transparency, patient privacy, payment clarity, and documentation standards for outpatient behavioral health services. It should be used together with Triad Psych, PC's current Notice of Privacy Practices, financial policies, telehealth policies, release-of-information forms, emergency procedures, and any separate authorizations required by law.

Key compliance insight: the strongest version of this document does not merely obtain a signature. It explains the patient's rights, the practice's duties, the limits of confidentiality, the difference between

ordinary clinical documentation and specially protected psychotherapy notes, the patient's financial responsibilities, and the situations in which separate written authorization may still be required.

This form should be reviewed periodically and whenever federal or Georgia law, payer rules, telehealth practices, technology vendors, documentation systems, or internal office procedures materially change. Final approval should be obtained from an appropriate Georgia healthcare attorney or compliance professional before patient use.

Compliance maintenance should include periodic review of HIPAA privacy and security policies, breach-response procedures, Business Associate Agreements, telehealth workflows, emergency protocols, financial disclosures, consent forms, Good Faith Estimate procedures, mandated-reporting procedures, and staff training records. Any change in practice operations should be reflected in the patient-facing documents and internal policies before continued use.

REGULATORY REFERENCES

This document references and should be reviewed for consistency with the following federal and Georgia authorities and guidance sources:

1. HIPAA Privacy Rule: Notice of Privacy Practices, 45 CFR § 164.520. This authority supports the requirement that patients receive adequate notice of how protected health information may be used and disclosed, as well as notice of patient rights and the covered entity's legal duties.

2. HHS Notice of Privacy Practices guidance. HHS explains that most covered health care providers must develop and distribute a Notice of Privacy Practices in plain language and that direct-treatment providers must make a good faith effort to obtain acknowledgment of receipt.

3. HIPAA Privacy Rule: Treatment, Payment, and Health Care Operations, 45 CFR § 164.506. This authority supports the consent language allowing use and disclosure of PHI for treatment coordination, payment activities, claims processing, health care operations, quality review, compliance review, and related administrative functions, subject to HIPAA limits.

4. HIPAA Privacy Rule: Authorizations and Psychotherapy Notes, 45 CFR § 164.508(a)(2). This authority supports a separate explanation of psychotherapy notes because psychotherapy notes generally require separate authorization for use or disclosure, except in limited circumstances permitted or required by law.

5. HHS mental health privacy guidance. HHS explains that psychotherapy notes are treated differently from other mental health information when they are kept separate from the medical record, and that they generally require patient authorization before disclosure, with limited exceptions.

6. No Surprises Act / Good Faith Estimate requirements, 45 CFR § 149.610. This authority supports providing uninsured or self-pay patients with a written Good Faith Estimate upon scheduling or request and explains the federal patient-provider dispute process when a final bill substantially exceeds the estimate.

7. Georgia child abuse mandated reporting, O.C.G.A. § 19-7-5. This authority supports the confidentiality exception for suspected child abuse, neglect, exploitation, sexual abuse, or other reportable child-safety concerns under Georgia law.

8. Georgia disabled adult and elder person protective reporting, O.C.G.A. § 30-5-4. This authority supports the confidentiality exception for suspected abuse, neglect, exploitation, or need for protective services involving disabled adults or elder persons under Georgia law.

9. Practice-specific policies requiring separate maintenance. This document should be maintained together with Triad Psych, PC's Notice of Privacy Practices, HIPAA policies, record-retention schedule, breached-information response plan, release-of-information forms, telehealth procedures, emergency/crisis protocol, financial policy, AI/vendor documentation policy, and Business Associate Agreement documentation for vendors that create, receive, maintain, or transmit PHI on behalf of the practice.

10. Georgia Board of Psychology rules and laws. The Georgia Secretary of State maintains the Georgia Board of Psychology rules and laws, which should be reviewed for current professional conduct, licensure, telepsychology, competence, recordkeeping, and ethical-practice requirements applicable to psychologists practicing in Georgia.

11. Georgia telepsychology requirements, Ga. Comp. R. & Regs. R. 510-5-.07. This authority supports telehealth language requiring appropriate licensure or authorization, professional and technical competence, emergency-resource planning, and the same legal and ethical standards that apply to in-person psychological services.

Reference and compliance note: statutory and regulatory citations are included for compliance orientation only. This document should be reviewed against the most current versions of federal law, Georgia law, Georgia licensing-board rules, payer requirements, HIPAA privacy and security obligations, professional ethics requirements, vendor agreements, and Triad Psych, PC's actual operations. The practice should confirm the final wording, applicability, implementation, and use of this form with qualified Georgia healthcare legal counsel or a compliance professional before distributing it to patients.