

ROSE NEUROSPA

10450 Park Meadows Dr., Suite 100 Lone Tree, CO 80124

720.707.6914

[www.rosenueropsa.com](http://www.rosenueropsa.com/)

# TREATMENT CONSENT FORM

Please read carefully, sign, and date the last page.

# SERVICES OFFERED

### SPRAVATO

Currently, we offer the ketamine nasal spray formulation known as Spravato, which is the only form of treatment covered by most insurance plans, including Medicaid.   Spravato treatments are provided in conjunction with integration coaching before and after each session. Our team works collaboratively with your existing mental health care provider or primary care physician, following protocols guided by the American Psychiatric Association.

### TMS

TMS therapy treats a multitude of mental health conditions, and more research is published every day. There are specific areas of the brain involved in mood regulation, and stimulating these areas can improve the brain’s ability to regulate mood. Antidepressants have worked to treat depression for many people since the 1980s, but they don’t work for everyone. TMS therapy isn’t an antidepressant medication. Instead, it works faster and with fewer side effects by using gentle magnetic pulses. These magnetic pulses have also proven to balance other key areas of the brain which help relieve symptoms from other mental health disorders including anxiety, PTSD, and others.

### MEDICATION MANAGEMENT

Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, our staff will discuss with you all the medication options that are available to treat your current condition. We will present information in language that you can understand. You will learn how the medication works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal affects you may experience if you stop taking the medication abruptly. By the end of the discussion, you will have all the information you need to make a rational decision as to which medication is right for you.

You may already be receiving psychotherapy from another therapist and are referred to our clinic for medication management. In this case we will make a strong effort to coordinate care with your therapist (with your consent, of course). We believe communication between mental health professionals is key to providing effective care.

Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage, frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy. Overall, our clinic is a strong proponent of the bio-psycho-social model of medical treatment. Treatment that considers your biological status, genetics, your psychological development, and social issues together will yield the best chance for success in achieving your goals.

### PSYCHOTHERAPY

Psychotherapy, or talk-therapy, is a powerful treatment for many mental complaints. It offers benefits of improved interpersonal relationships, stress reduction, and a deeper insight into one's own life, values, goals, and development. It requires a great deal of motivation, discipline, and work on both parties for a therapeutic relationship to be an effective one. Clients will have varying success depending on the severity of their complaints, their capacity for introspection, and their motivation to apply what is learned outside of sessions.

Clients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings, and sensations such as guilt, anxiety, anger, or sadness, especially in its initial phases.

It is not uncommon for these feelings to have an impact on current relationships you may have. If this occurs, it is very important to address these issues in session. Usually, these unpleasant sensations are short lived.

At your initial visit, we will conduct a thorough review of your current complaints and of your background. By the end of the initial visit, we will offer preliminary impressions, and we will discuss your treatment options. Sometimes, psychotherapy alone will suffice. Often times, however, a combination of psychotherapy and medication management is optimal. One of the most important curative aspects of a therapeutic relationship is the goodness-of-fit between therapist and client, so, the initial visit is also your opportunity to determine for yourself if practitioners at our practice or our other licensed counseling staff is the right therapist for you. If you feel that our providers not well matched to your needs, I would be happy to provide you referrals to other mental health professionals.

# FREQUENCY AND DURATION OF VISITS

At your initial sixty-minute consultation, we will decide together the structure of your treatment. If medications are prescribed, or changed, we prefer to conduct a 30-minute follow-up visit in three to four weeks. This is necessary to ensure proper administration and minimize any side affects you may experience. If your symptoms improve, follow-up visits can be spaced out at monthly intervals. For clients on maintenance therapy, follow-up visits can be held at three-month intervals. If you are to undertake psychotherapy, weekly 60-minute sessions will provide the best results. We may discuss an alternate treatment structure depending on your circumstances.

# FEES

### INSURANCE POLICIES

Rose NueroSpa currently accepts most major insurance companies.

### SELF PAY FEES

* 1. Initial consultation (60 minutes): $300.00
  2. Psychotherapy with Psychiatrist (60 minutes): $250.00
  3. Psychotherapy with Therapist (60 minutes): $200.00
  4. Medication Management (30 minutes): $150.00

Fees are subject to change. If any fees are to increase, our office will provide thirty days’ prior notice of such change.

# CANCELLATIONS AND NO-SHOWS

If you cancel or reschedule an appointment, our office requires at least 24-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the on the preceding Friday. Cancellations that occur with less than 24-hour notice or failure to show to an appointment will be charged the full fee for the session.

# PAYMENTS

We will expect payment at the beginning of each session, unless we have agreed on other arrangements. We accept cash or personal check, and major credit cards. Checks should be made payable to “Rose NeuroSpa." If payment is 60 days past due, we reserve the right to utilize legal resources such as collection agencies or small claims court to obtain payment for our services.

# MEDICAL RECORDS

We are required by law to keep complete medical records. Most medical records will be electronic, encrypted, and under fingerprint security. Any written records including the initial consent forms, letters, outside medical records, will be kept locked. You are entitled to review your medical record at any time, unless we feel that by viewing your records, your emotional or physical well-being will be jeopardized. If you wish to view your records, we recommend that we review them together to minimize

any confusion or misinterpretation of medical terms. Time spent collecting, printing, copying, and summarizing the medical record will be charged the appropriate fee (see above)

# CONFIDENTIALITY

The security of your sensitive information is of utmost importance to our clinic, and we are bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent. As described above, basic information about your treatment may be disclosed to your insurance company for purposes of prior authorization if necessary.

There are exceptions to this confidentiality, where disclosure is mandatory. These include the following:

1. If there is a threat to the safety of others, we are required by law to take protective measures including reporting the threat to the potential victim, notifying police, and seeking hospitalization.
2. When there is a threat of harm to yourself, we are required to seek immediate hospitalization, and will likely seek the aid of family members or friends to ensure your safety.
3. In legal hearings, you do have the right to refuse my involvement in the hearing. There are rare circumstances, however, in which we will be required by a judge to testify on your emotional, or cognitive condition.
4. In situations where a dementing illness, epilepsy or other cognitive dysfunction prevent you from operating a motor vehicle in a safe manner, we will be required to report this to the DMV.
5. If a mental illness prevents you from providing for your own basic needs such as food, watery shelter, we will be required to disclose information to seek hospitalization.

These situations rarely occur in an outpatient setting. If they do arise, we will do our best to discuss the situation with you before taking action. In rare circumstances, we may find it helpful to consult with other professionals specialized in such situations (without disclosing your identity to them). Our HIPAA policies are available for you to review.

# THE PRACTICE

While our office has several mental health professionals, our medical records are kept secure and separate. If we refer you to another community therapist or physician, we may find it helpful to collaborate and coordinate your care, and this will require your written consent.

# CONTACT INFORMATION

If you choose to contact our office via e-mail, please be aware that e-mail is not a secure means of communicating sensitive mental health information. While we check e-mail regularly, it is not an appropriate way of contacting our office in an emergency. Please contact our office at 720.707.6914 during normal business hours if you would like to speak with a provider.

We do not provide after-hours emergency care, or care for emergencies that may arise on weekends or holidays. If you are having a medical or psychiatric emergency, please call 911 or go to your nearest emergency room.

# CONTROLLED SUBSTANCE POLICY

Should controlled substances be prescribed during your visit you agree to only receive such substances from this office. Receiving controlled substances of the same class from other physicians while receiving them from our practice will result in immediate dismissal from this practice. In accordance with current DEA guidelines, if prescribed controlled substances, you consent to random urine drug screening and understand that the prescription drug monitoring database will be reviewed at each visit.

# Patient Rights

You have the right to:

* A personal clinician who will see you on an on-going, regular basis.
* Competent, considerate, and respectful health care regardless of race, creed, age, sex or sexual orientation.
* A second medical opinion from the clinician of your choice, at your expense.
* A complete, easily understandable explanation of your condition, treatment, and chances for recovery.
* The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
* Confidential management of communication and records pertaining to your medical care.
* Information about the medical consequences of exercising your right to refuse treatment.
* The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
* An individualized treatment plan.
* An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
* The opportunity should a dispute arise regarding care, to select a different clinician at another practice.

# Medical Student Policy

Our clinic is seeking registration as a teaching site for medical education for various medical programs in Colorado. As such, medical students may from time to time be present to shadow one our providers and by signing this consent, you acknowledge and consent to medical students or other trainees to "shadowing” during your session. All trainees are HIPAA certified and will maintain your confidentiality. If you do not desire the medical student to be present during your session, you of course have the right to refuse their presence during your examination by letting our front office staff aware of your preference.

# TREATMENT CONSENT

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of the clinic’s services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality, the nature of our practice, and our contact information, and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

Client name (please print): ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Client's Signature: ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Executive Director Signature:

**TELEHEALTH CONSENT**

On occasion our clinic may necessitate or require telemedicine visits due to extenuating circumstances such as the current public health crisis or due to clinician accessibility. Please indicate your willingness to participate in telemedicine appointments.

## **AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION**

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with any provider at Rose NeuroSpa

* + Medical Information and Records. All existing laws regarding your access to medical information and copies of your medical records apply to telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.
  + Confidentiality. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and State law apply to information disclosed during this telemedicine consultation.
  + Risks and Consequences. The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance.

I have been advised of all the potential risks, consequences, and benefits of telemedicine. I understand the written information provided above.

Signature: Date: Patient (or person authorized to give consent)

PATIENT INTAKE FORM

Client’s Full Legal Name: Date:

Preferred Name: Pronouns:

DOB: Age: Gender Identity:

Sexual Orientation: Marital Status:

Partner/Spouse Name:

Legal Custodian (if applicable):

**Employment Information**

Are you currently employed?  Yes  No

Employer Name:

Employer City: Employer State:

**Primary Physician Information**

Do you have a Primary Physician:  Yes  No

Name of Primary Physician:

Name of Clinic:

Clinic City: Clinic State: Date of last exam?

Name of Preferred Pharmacy:

Pharmacy Address:

Pharmacy City: Pharmacy State:

**Therapist Information (if any)**

Name of Therapist: Clinic:

Clinic City: Clinic State:

**Mental and Medical Health Concerns/History**

What concerns are you seeking to treat with medications or other non-drug alternatives, and how do you think they can help?

Is treatment required or requested by your employer, a court of law, or as a part of mental health commitment?  Yes  No

If yes, explain (County, Case Manager info):

Have you been diagnosed with any conditions (medical and/or mental health) in the past?  Yes  No

If yes, list all previous diagnoses you have received (medical and/or mental health)

Current Life Stressors:

Are you currently taking any medications (prescribed or over-the-counter)?  Yes  No

Please list all **CURRENT MEDICATIONS** (prescribed or over-the-counter) you are currently taking:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | Dosage | Frequency | Date Started (MM/YYYY) | Scheduled or as needed (PRN) | Adverse effects  (if any) |
|  |  |  |  |  |  |
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Have you taken any mental health medications (prescribed or over-the-counter) in the past?  Yes  No

Please list all **PAST MENTAL HEALTH** medications (prescribed or over-the-counter) and reasons for stopping:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medication | Max Dosage | Frequency | Date Started (MM/YYYY) | Date stopped (MM/YYYY) | Adverse Effects  (if any) |
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Are you allergic to any medications or drugs?  Yes  No If yes, list medication and reaction:

Please provide information regarding your blood relatives. \*\*NOTE: This section can be blank IF the patient is adopted or information is unknown.

Mother:  Living  Deceased

 Bleeding/Clotting Disorders or Stroke  Diabetes

 Heart Disease/Arrhythmia  Mental Illness Suicide

Father:  Living  Deceased

 Bleeding/Clotting Disorders or Stroke  Diabetes

 Heart Disease/Arrhythmia  Mental Illness Suicide

Brother(s):  Living  Deceased

 Bleeding/Clotting Disorders or Stroke  Diabetes

 Heart Disease/Arrhythmia  Mental Illness Suicide

Sister(s):  Living  Deceased

 Bleeding/Clotting Disorders or Stroke  Diabetes

 Heart Disease/Arrhythmia  Mental Illness Suicide

Children:  Living  Deceased

 Bleeding/Clotting Disorders or Stroke  Diabetes

 Heart Disease/Arrhythmia  Mental Illness Suicide

Maternal Grandmother:  Living  Deceased

 Bleeding/Clotting Disorders or Stroke  Diabetes

 Heart Disease/Arrhythmia  Mental Illness Suicide

Maternal Grandfather:  Living  Deceased

 Bleeding/Clotting Disorders or Stroke  Diabetes

 Heart Disease/Arrhythmia  Mental Illness Suicide

Paternal Grandmother:  Living  Deceased

 Bleeding/Clotting Disorders or Stroke  Diabetes

 Heart Disease/Arrhythmia  Mental Illness Suicide

Paternal Grandfather:  Living  Deceased

 Bleeding/Clotting Disorders or Stroke  Diabetes

 Heart Disease/Arrhythmia  Mental Illness Suicide Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chemical/Substance Use History**

Please provide information on past and/or current chemical use history (if applicable):

|  |  |  |  |
| --- | --- | --- | --- |
|  | Never | Current | Past |
| Caffeine |  |  |  |
| Alcohol |  |  |  |
| Nicotine |  |  |  |
| Marijuana |  |  |  |
| Cocaine/Crack |  |  |  |
| Heroin/Opiates |  |  |  |
| Inhalants |  |  |  |
| Hallucinogens |  |  |  |
| Methamphetamine |  |  |  |
| Prescription Drugs |  |  |  |
| Valium/Librium/Xanax/Benzodiazepines |  |  |  |
| Over-the-Counter |  |  |  |

Please list any others not in the above list:

**Mental Health Treatment History**

Please provide your history with the following treatments or conditions:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | Month/Year(s) | Facility/Clinic |
| Counseling/Psychotherapy |  |  |  |  |
| Drug/Alcohol Treatment |  |  |  |  |
| Inpatient Treatment |  |  |  |  |
| Groups, PHP or IOP |  |  |  |  |
| Genetic Testing |  |  |  |  |
| Psychological Testing |  |  |  |  |

Please list any others not in the above list:

Please provide your history with the following:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Month/Year(s) |
| Self-Harm |  |  |  |
| Suicidal Ideation |  |  |  |
| Suicide Attempts |  |  |  |

**Insurance:**

Insurance information:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Primary Insurance | Policy # | Group # | Policy Holder  (Subscriber Name) | Date of Birth | Relation to Patient |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Secondary Insurance | Policy # | Group # | Policy Holder  (Subscriber Name) | Date of Birth | Relation to Patient |
|  |  |  |  |  |  |

**Personal History**

Tell us about your education:

What is your marital/relationship status?

Tell us about your current friends/relationship connections:

Who do you live with?

What are your favorite hobbies/sports/activities?

Tell us what your typical nutrition/diet consists of:

Tell us about your sleep habits:

Tell us about your exercise/physical activity habits:

Do you have a history of trauma or abuse:

Emergency Contact:

|  |  |  |
| --- | --- | --- |
| Relationship | Address | Phone |
|  |  |  |

Once I have been seen by a provider that has determined care can be provided at Rose NeuroSpa and agrees to provide necessary treatments, I consent to treatment by Rose NeuroSpa and I understand that payment is to be made at the time of the treatment and that I am financially responsible for all scheduled appointments unless a minimum of 24 hours' notice is given. I authorize my provider of care to release my treatment records, as required, to my insurance carrier(s) for the purpose of obtaining reimbursement. I also authorize provider of care to release my treatment records as required to the clinic’s billing company for purpose of billing insurance carriers. I authorize payment of reasonable and customary charges to the provider of services. I also acknowledge that I have reviewed and consent to the Privacy Practices of Rose NeuroSpa.

Signature of Patient/Guardian: Date:

**Release of Information**

I hereby authorize Rose NeuroSpa to release and acquire Personal Health Information (PHI) to/from the following individuals:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Address** | **Telephone** | **Fax** |
|  |  |  |  |
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The information requested or authorized for release or exchange pertains to:

* Mental Health  Drug/Alcohol Substance Use  Education  Other

This authorization is valid for 365 days from the date. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re- disclose it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Patient's Name:

Patient's Signature:

Guardian's Signature (if patient is a minor):

Date of Birth:

Date