

Psychiatric Provider Consent

** indicates a required field*

Treatment Information:

I consent to psychiatric treatment provided by a **PMHNP-BC** ("psychiatric provider") at **The Psychology Lab**. This treatment may include evaluation, diagnosis, treatment planning, medication management, and complementary recommendations such as supplements or lifestyle changes.

Treatment Policies

1. You must complete all intake and consent forms at least **24 hours before** your scheduled appointment. Failure to do so may require rescheduling.
2. Signing this consent is required prior to receiving psychiatric services at The Psychology Lab. Declining to sign will result in referral to another provider.
3. The provider may require at least **three months of treatment** before completing disability or workplace-related paperwork.
4. Submission of forms (e.g., ESA letters, disability, FMLA) does **not guarantee approval** by outside organizations.
5. The Psychology Lab will **fax or send completed paperwork** within 72 business hours of provider completion.
6. Paperwork completion is at the provider's discretion and only if deemed clinically appropriate.
7. **Medical records requests** will be processed within 21 to **30 days** of written request.
8. The provider will **not participate in legal cases** without a signed contract; legal involvement is billed at **\$350+/hour**.
9. **Crisis services are not provided**. For emergencies, call **988, 911**, or go to the nearest emergency room.
10. **Non-urgent messages** (voicemails, texts, emails) will be returned within **72 business hours**.
11. **Billing inquiries** may take **7–14 business days**, or longer if affected by external healthcare changes.
12. If you have not been seen in **6 months or more**, a **new psychiatric evaluation** is required.
13. External psychiatric evaluations are **not accepted** in place of The Psychology Lab's own evaluation.
14. You may request a **second opinion or change providers** at any time.

15. It is the patient's responsibility to notify the provider of their current contact information to include a working phone number and an accurate residing address.

Purpose of Treatment

The goal of psychiatric treatment is to manage mental health conditions and improve your overall well-being. While benefits may include reduced symptoms and better functioning, **results are not guaranteed.**

Risks and Benefits

Treatment may involve:

- Medication side effects or reactions
- Emotional discomfort during sessions
- Unexpected challenges during care

If you experience serious side effects or mental health crises, **seek immediate emergency care.**

Laboratory Testing

Your provider may recommend genetic, blood, or specialty tests to guide treatment. These may carry costs billed separately by the laboratory and may not be covered by your insurance plan.

Telepsychiatry Services

Telepsychiatry is available via **Simple Practice**, a HIPAA-compliant platform. You must be physically located in **Arizona** at the time of your appointment. The provider or patient can discontinue a telehealth session if the connection is inadequate. Risks include technical failures and reduced assessment capability.

Telephone Consults

Occasional telephone (audio-only) consultations may be permitted, but they limit diagnostic capability. You must agree to any follow-up instructions and attend in-person or video sessions if requested.

Email & Text Communication

Email and text are not secure. Use Simple Practice for secure messaging. Email/text should not be used for sensitive topics (e.g., substance use, STIs). You may revoke consent for electronic communication at any time.

Confidentiality

Information is confidential unless:

- You are at risk of harming yourself or others
- Abuse or neglect is suspected
- Information is shared for educational purposes without identifying you
- Required by law

Your provider may discuss your case with clinical team members or students unless you opt out.

AI Scribe Use

To improve care efficiency, your provider may use a HIPAA-compliant AI scribe to generate medical notes. These notes are stored only in your official medical record. You may revoke consent at any time in writing.

Medication Consent

You may be prescribed psychiatric medications. You have the right to ask questions and may stop medication at any time by informing your provider.

Prescriptions:

- Are limited to Arizona pharmacies
- May require labs, cardiac clearance, or pharmacy communication

- Cannot be refilled without up-to-date appointments or labs

Controlled medications (e.g., stimulants) may require in-person visits and additional policies.

Controlled Substance Agreement

You agree to:

- Take medications as prescribed
- Avoid illegal drugs and alcohol
- Submit to random drug screens or pill counts
- Notify the provider if prescribed other controlled substances
- Accept non-replacement of lost or stolen meds
- Refill only during appointments (no early refills)

Failure to follow these terms may result in discontinuation of treatment.

Refills

- Refills occur during scheduled appointments
 - Allow up to **72 business hours** for processing
 - Missed or late appointments may delay refills
 - Outstanding balances must be addressed before refills are granted
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Patient Rights

You have the right to:

- Access your medical records

- Revoke consent at any time (except for services already rendered)
 - Receive in-person care as an alternative to telehealth
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Patient Responsibilities

You agree to:

- Use 911 or crisis services for emergencies
 - Maintain honesty around custody, legal, and substance use issues.
 - Show up on time. Your appointment may be rescheduled if you arrive later than 10 minutes for a scheduled appointment.
 - Notify the provider if you'll be late.
 - Test your electronic equipment and internet connection prior to telepsychiatry sessions.
 - Maintain sobriety during sessions
 - Follow up as recommended and maintain a credit card on file
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Payment & Insurance

- Self-pay rates: \$225 initial, \$175 urgent, \$150 follow-up, AHCCCS patients are out of network and may be offered a reduced fee option.
- No-shows or late cancellations (<24 hours) incur a **fee of \$50 up to \$150 [based on insurance allowable amount]**.
- Insurance issues or missed info may result in services transitioning to a self pay status
- We may offer superbills or reimbursement forms on a case by case

Paperwork, Letters, and Forms [This is a self-pay service only and cannot be billed through insurance]

Any paperwork, documentation, or written communication outside of what is covered by standard billing codes is billed directly to the patient. This includes, but is not limited to:

- Emotional Support Animal (ESA) letters
- Housing or accommodation letters
- Insurance forms or documentation requests
- Short-term disability or FMLA/leave-of-absence paperwork
- Employment, school, or legal letters
- Any form of letter writing, narrative summaries, or administrative documentation not billable to insurance

Paperwork is billed at **\$35 per 15 minutes**, including review, preparation, and completion time.

By requesting paperwork, you acknowledge and agree to these self-pay rates.

Supplement Recommendations

Supplements may be suggested to support your mental health. You have the right to decline or discontinue use at any time.

Disclaimer

Treatment is not guaranteed to produce results. Referrals or discharge may occur if your provider determines your needs exceed their scope.

Limits and Termination

Care may be terminated for:

- Disrespect, noncompliance, or unsafe behavior
- No-shows, unpaid balances, or medication misuse
- Situations requiring higher-level care

You will be provided with referrals and a 30- to 90-day bridge when appropriate.

Release of Information

You may limit or revoke how your information is shared by providing written notice. Some disclosures may already be acted upon and not retractable.

Acknowledgment

By signing, I confirm I understand and agree to the terms of psychiatric care described above, including all policies, risks, and responsibilities.

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*** I have reviewed the information on this document, had the opportunity to ask questions, and have received answers to my satisfaction. BY SIGNING BELOW I/WE AGREE THAT I/WE HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT AND CONSENT FOR SERVICES.**
