



JCE Health

Psychiatry & Functional Medicine

Geidy Rivers, DNP, AAPRN, FNP, PMHNP

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CONSENT FOR TREATMENT:

_____ (Initials)

I hereby voluntarily request diagnostic evaluation and medical treatment, which may include individual, family, couples, and group therapy, medication management, consultation, education, and referral to other community resources, provided by Geidy Rivers, APRN, JCE Health, LLC and its providers. By writing and signing my name below, I agree with and understand the following:

1. The purpose of treatment.
2. Possible alternative treatment exists.
3. Treatment includes potential risk and benefits.
4. The risks may be irreversible and may include increased suicide risk and death, when treated with psychotropic medications.
5. No diagnostic or therapeutic guarantees have been made.
6. My participation in treatment is voluntary, and I may stop at any time.
7. I agree not to sue Geidy Rivers, JCE Health, LLC and its providers in a Civil or Medical Malpractice Lawsuit.
8. I agree to seek Legal Mediation if there is a disagreement with my treatment plan, which is, if after, both parties try to resolve the issue between us without attorneys involved.
9. I agree to pay all my attorney fees and do not expect Geidy Rivers, JCE Health, LLC and its providers to cover these expenses.
10. I understand that Geidy Rivers, JCE Health, LLC and its providers have my health as their main priority. I also understand the risk and benefits of using psychotropic medications. These may have permanent, irreversible side effects and even cause death. I legally waive Geidy Rivers, JCE Health, LLC and its affiliates and providers for these risks and agree to try to resolve any issue with Legal Mediation and not a Civil or Medical Lawsuit.
11. I understand that I may be discharged from the practice if my behavior is considered non-compliant and not safe by the providers. This may include missing appointments, unpaid balances, being disrespectful to staff and other patients, being loud and inappropriate, threatening to others, lying, drug-seeking behavior, over using medications, doctor shopping, stealing, and other reasons that the provider may think it is not a good therapeutic rapport with the patient.
12. You shall be given 30 days written notice as stated by the State of Florida, to get another Provider.

My name and signature below certifies my understanding and acceptance of the intent of this informed consent.

NOTICE OF PRIVATE PRIVACY ACKNOWLEDGEMENT: _____ (Initials)

1. I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.
2. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
3. Obtain payment from third party payors, conduct normal healthcare operations such as quality assessments and physician certifications I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.
4. I understand that Geidy Rivers, JCE Health, LLC and its providers have the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.
5. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree, then you are bound to abide by such restrictions.

LABORATORY TESTS: _____ (Initials)

I understand that Geidy Rivers APRN (henceforth referred to as "the practitioner") / the practice may recommend blood, saliva, stool, urine, hair, or skin testing within their scope of practice. In addition to conventional testing, specific tests may be ordered through specialized laboratories to assess structural and/or functional deficiencies, and may not always be diagnostic, but can provide critical information to help improve my health outcomes. I agree with the use of such tests and will always have the opportunity to discuss their applicability and limitations with my provider, prior to sample collection. I agree to pay the laboratory any fees due for sample collection and processing.

TELEHEALTH CONSENT: _____ (Initials)

I consent to voluntarily engaging in a telemedicine consultation with the practice. I understand that the video conferencing technology will not be the same as a direct patient/health care provider visit:

Telehealth consultation has potential benefits, including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home. It also has potential risks including interruptions, unauthorized access, and technical difficulties.

I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

If there is another individual present during the telehealth consultation, I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and or (3) terminate the consultation at any time.

I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through the practice will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.

Telemedicine services offered through the practice are not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgentcare.

To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

TELEPHONE CONSULTATION CONSENT:

_____ (Initials)

I understand that the practitioner / the practice may, on rare occasions, allow telephone consultations - verbal conversation only / no video. I understand that these consultations have considerable limitations, including but not limited to no physical exam or visual assessment. I understand that my provider, during the telephone consultation, may determine that adequate care and treatment will not be possible with the limited assessment via telephone consultation. I agree to follow through with them on any required in-person office visits or video telehealth visits. I consent to receive instructions via phone/telemedicine platform and take full responsibility to follow through with specific instructions as required for my treatment. I have had the opportunity to discuss the limitations with my provider.

EMAIL USE CONSENT:

_____ (Initials)

The preferred method of communication is via HIPPA-compliant Patient Portal. However, the practitioner / the practice provides patients with the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks: E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily copy information.

It is the policy of the practitioner / practice that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of the patient's protected personal health information. The practice cannot guarantee the security and confidentiality of e-mail or internet communication.

Patients may consent to the use of e-mail for confidential medical information after having been informed of the above risks with the following conditions: All e-mails to or from patients concerning diagnosis and/or treatment will be made part of the protected personal health information. As a part of the protected personal health information, other individuals, insurance coordinators and, upon written authorization, other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.

The practitioner / practice will endeavor to read e-mail promptly. However, the practice can provide no assurance that the e-mail will be read immediately.

Therefore, e-mail must never be used in a medical emergency.

Because some medical information is so sensitive that unauthorized disclosure can be damaging, e-mail should not be used for communications concerning diagnosis or treatment of any sexually transmittable or communicable diseases such as syphilis, gonorrhea, and the like; behavioral health, mental health; or alcohol and drug abuse.

The practitioner / practice cannot guarantee that electronic communications will be private. The practitioner / practice is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct and is not liable for breaches of confidentiality caused by the patient.

I understand that my consent to the use of e-mail may be withdrawn at any time, whether it be by e-mail or written communication to the practitioner / practice. I have read this form carefully and understand the risks and responsibility associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail

APPOINTMENT REMINDERS CONSENT: _____ (Initials)

The practitioner / practice may need to use my name, address, phone number, and my clinical records to contact me with appointment reminders/text message, information about treatment alternatives or other health related information that may be of interest to me. If this contact is made by phone and I am not available, a message will be left on my answering machine or with the person answering the phone.

By signing this form, I am giving the practice the authorization to contact me with these reminders and information and to leave a message on my answering machine or with individuals at my home or place of employment.

RELEASE OF INFORMATION: _____ (Initials)

I may restrict the individuals or organizations to which your health care information is released or I may revoke your authorization at any time: however, this revocation must be in writing and mailed to the office address. The practice will not be able to honor my revocation request if they have already released my health information before the request to revoke authorization. In addition, if I was required to give my authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that the practice may use or disclose based on the authorization I am giving may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. I have the right to refuse to give us this authorization. If I do not give authorization, it will not affect the treatment I receive or the methods used to obtain reimbursement for my care.

I may inspect or copy the information that is used to contact me to provide appointment reminders, information about treatment alternatives, or other health information at any time.

This notice is effective on the date of signature. This authorization will expire seven years after the date on which I last receive services from the practice.

I authorize you to use or disclose my health information in the manner described above. I acknowledge that I have received a copy of this authorization.

I do not expect the provider to be able to anticipate and explain all risks and complications, and I wish to rely on the provider to exercise judgment during the course of the treatment which the provider feels at the time, based upon the facts then known, is in my best interests.

My name and signature below certifies my understanding and acceptance of the intent of this Informed Consent and Notice of Privacy Practice and all policies listed in this document:

****If I do not agree with these terms, I will not sign this agreement and I will seek help elsewhere. ****

PATINET NAME

_____/_____/_____
DATE

PATINET SIGNATURE