Montani Mental Health

1137 Van Voorhis Road, Unit 44 Up

Morgantown, WV 26505

Phone: 304-282-0588

At **Montani Mental Health**, we are committed to your treatment and using your protected mental health information responsibly. This notice describes the personal information we collect and how, when, and why we use or disclose your information. This notice is **effective December 1st, 2020** and applies to all protected mental health information as defined by federal regulations.

Mental Health Record:

Each time you visit our office, documentation is made regarding your treatment. This record may contain your symptoms, test results, diagnoses, medications, current treatment and a future treatment plan. This record is the property of Montani Mental Health, LLC, and may be released with proper documentation/releases.

…I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

…I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

Contact Information:

…I have received a copy of my practitioner's contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable).

…I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Telebehavioral Health:

…I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from Montani Mental Health, LLC and other persons involved in my health care.

…I authorize the use of Telebehavioral Health in the form of synchronous (Zoom, phone calls) and asynchronous (email, text message) contact in my treatment.

Financial Policy:

All co-payments, deductibles, and coinsurance amounts are due and payable at the time of service, unless prior arrangements with our billing department have been made. All patients' accounts are due and payable within 30 days of services rendered. As a courtesy, our practice will establish a monthly payment plan to accommodate your needs.

You will receive a monthly statement showing current dates of service and any balance due from you. We ask that payment be made within 15 days of your statement date unless prior arrangements have been established.

Neglecting to remit payment after 61 days of balance due notice or financial agreement will force us to limit future credit until past due balance is settled. At this point, your account will be sent to our collection agency.

…I agree to abide by the financial policy of Montani Mental Health, LLC.

Attendance Policy:

Appointments can be made in person or by calling our office. There is no charge for appointments that are cancelled 24 hours in advance of the scheduled appointment time. Patients have the option to cancel by calling our office and speaking directly with a member of our staff, leaving a voicemail, or sending an email to the office email at info@montanimentalhealth.com.

Please note that after THREE no call/no show instances, you will be terminated from our therapy clinic for non-compliance. You will still be responsible for any balance left on your account.

CANCELLATIONS AND NO SHOWS ARE SUBJECTED TO A $25.00 FEE.

…I agree to abide by the cancellation policy of Montani Mental Health LLC and understand that my treatment will be terminated if I am not in compliance.

Consent to Treatment:

I voluntarily agree to receive mental health assessment, care, treatment or services and I authorize the office of Montani Mental Health to provide such care, treatment, or services as are considered necessary or advisable.

By signing this form, I, the undersigned, acknowledge that I have both read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions regarding anything that is unclear to me.

_____ _____

Signature of patient or responsible party **Date**

_____ _____

As witnessed by **Date**