Paperflower Psychiatry, LLC

Updated Consent to Treatment and Telepsychiatry 2024

Please read carefully sign where indicated.

Treatment Information :

I, the undersigned, hereby consent to psychiatric treatment provided by Paperflower Psychiatry, LLC. I understand that this treatment includes an evaluation, treatment recommendations and/or medication management. I understand Paperflower Psychiatry, LLC does not perform any therapy or counseling services, although they can provide me with referrals. I understand that in addition to traditional psychiatric interventions, my treatment plan may include recommendations for dietary supplements to support my mental well-being.

Purpose of Treatment:

I understand that the purpose of psychiatric treatment is to address and manage mental health conditions, symptoms, and concerns. The goals of treatment may include:

- Alleviating symptoms including but not limited to depression, anxiety, and mood swings.
- Improving overall mental well-being and quality of life

Benefits and Risks:

I acknowledge that while psychiatric treatment may offer potential benefits, there are also inherent risks and limitations. These may include:

- Possible side effects or adverse reactions to medications
- Emotional discomfort during appointments
- Unforeseen challenges in treatment progress

Telepsychiatry Services

Telepsychiatry is the delivery of psychiatric services using electronic visual conferencing systems between a provider and a patient that are not in the same physical location. The conferencing tools used in Telepsychiatry incorporate software security protocols to protect the confidentiality of patient information including audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. All initial evaluations require video. Platforms

such as doxy.me or Facetime may be utilized if doxy.me is unavailable. You must acknowledge that FaceTime may not be secure if this is the chosen platform.

Potential Benefits

Increased access to psychiatric care, patient convenience, time-saving without required travel.

Potential Risks

Breach of confidentiality, poor resolution of video, delays in evaluation due to failures of equipment, lack of access to all information available in a face-to-face visit which may result in an error of medical judgment.

Alternatives to the Use of Telepsychiatry

Medication management through in-person appointments.

Confidentiality

Information about the patient will only be released with his or express written permission, with the exceptions of the following cases: (1) if the provider determines risk of self- harm, (2) if the provider determines risk of harm to others, (3) if the provider is informed about or suspects abuse, neglect, or exploitation of a minor or of an incapacitated adult, (4) for educational purposes with no identifying information to nurse practitioner preceptor students or (5) if the provider believes that someone's mental condition leaves the person gravely disabled. You may request to not have information provided to NP students and to not have them present for evaluations.

The provider will maintain records of online treatment and /or consultation services.

All clinical records will be maintained as required by applicable legal and ethical standards.

AI Scribe Usage

I hereby authorize providers at Paperflower Psychiatry LLC and associated healthcare personnel to utilize an Artificial Intelligence (AI) scribe for the purpose of documenting and transcribing medical notes related to my psychiatric care. I understand that the AI scribe may assist in the creation, organization, and storage of my healthcare information.

Purpose of AI Scribe Usage:

'In an effort to spend more time meaningfully engaged with clients some providers engage use of a scribe service that prepares a summary and chart note based off of our interaction. It does not keep this content beyond the generation of any information and it is erased end of the day from the AI software. The only written or saved information resides in the note your provider posts in your medical chart. The AI scribe will be used by your provider at Paperflower Psychiatry LLC to accurately and efficiently document our clinical interactions, including but not limited to:

- Assessment of psychiatric symptoms and conditions
- Treatment plans and medication management
- Progress notes and follow-up appointments
- Other relevant information pertinent to my psychiatric care

Understanding of HIPAA Regulations:

I acknowledge that the utilization of an AI scribe involves the processing and storage of my protected health information (PHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that my PHI will be safeguarded according to HIPAA regulations and any applicable state laws.

Confidentiality and Security Measures:

I understand that my Paperflower Psychiatry LLC provider and the healthcare organization will take appropriate measures to maintain the confidentiality and security of my healthcare information. This includes implementing safeguards to protect against unauthorized access, disclosure, alteration, or destruction of my PHI.

Revocation of Consent:

I understand that I have the right to revoke this consent at any time, except to the extent that action has already been taken in reliance on this consent. Revocation of consent must be submitted in writing to Paperflower Psychiatry LLC.

Patient Rights:

I understand that I have certain rights regarding my healthcare information, including the right to access, request amendments to, and receive an accounting of disclosures regarding my PHI. I further understand that I may exercise these rights by contacting Paperflower Psychiatry LLC.

Effective Date:

I understand the contents of this consent form and voluntarily consent to the use of an AI scribe for my psychiatric care

Medication Consent

Purpose of Psychotropic Medications:

I understand that psychotropic medications, including but not limited to antidepressants, antipsychotics, mood stabilizers, and anxiolytics, may be recommended as part of my treatment plan. These medications aim to alleviate symptoms of mental illness, regulate mood, and improve overall functioning.

Benefits and Risks:

I understand that the benefits of psychotropic medications may include symptom reduction, improved mood, enhanced quality of life, and increased ability to engage in daily activities. However, I acknowledge that there are potential risks associated with medication use, including side effects, adverse reactions, and the need for regular monitoring.

Informed Decision:

I have been provided with information regarding the potential benefits, risks, and alternatives to psychotropic medications. I understand that I have the right to ask questions and seek clarification about any aspect of my treatment plan before providing consent.

Voluntary Consent:

I voluntarily consent to initiate and/or continue treatment with psychotropic medications as recommended by my psychiatrist. I understand that I have the right to refuse or discontinue medication use at any time, and I will inform my psychiatrist if I choose to do so. By signing this document, I consent to receiving any or all prescriptions by Paperflower Psychiatry, LLC. If I am a guardian, I consent to my child or the person in my care to receiving all prescriptions from Paperflower Psychiatry, LLC.

Confidentiality:

I understand that my psychiatric evaluation and treatment, including medication management, will be kept confidential in accordance with applicable laws and ethical

guidelines. Information about my treatment will only be shared with authorized healthcare providers involved in my care.

Follow-Up and Monitoring:

I agree to attend follow-up appointments as scheduled to monitor the effectiveness of psychotropic medications and assess for any adverse effects. I understand that regular communication with my psychiatrist is essential for optimizing my mental health outcomes.

Patient's Rights

I understand that the HIPPA laws that protect the privacy and confidentiality of medical information also apply to Telepsychiatry. Paperflower Psychiatry, LLC utilizes a HIPPA compliant Video Services.

I have the right to withhold or withdraw my consent to the use of telepsychiatry services during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment. In person appointments are an option.

I have the right to inspect all medical information that includes the telepsychiatry visit. I may obtain copies of this medical record information upon request. I understand that for printed copies, there may be a fee included. If charts or reports are required for legal purposes including court appearances, a fee will also apply.

I understand that my provider has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time.

I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.

Patient's Responsibilities

I will contact or go to an urgent care, call 911 or emergency psychiatric service if an emergency or crisis occurs. I will not contact Paperflower Psychiatry until receiving urgent, crisis or emergency care.

I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.

I will inform Paperflower Psychiatry, LLC if any other person can hear or see any part of our session before the session begins to protect privacy.

I understand that Paperflower Psychiatric, LLC has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time

I understand that all rules and regulations which apply to the practice of medicine in the State of Arizona also apply to telepsychiatry.

I understand that I MUST be a resident of Arizona to be eligible for telepsychiatry services from Paperflower Psychiatry, LLC.

I understand I may receive in-person services at Paperflower Psychiatry, LLC even if not a resident in the state of Arizona.

I will provide all truthful information regarding legal information including but not limited to medical decision making for childhood, custody concerns, disagreement with the other guardian regarding medication or psychiatric treatment.

If the child I am a guardian for is receiving treatment, I agree to be available and present for each appointment by Paperflower Psychiatry, LLC.

If the child I am a guardian for is receiving treatment, I agree the child will be present at every appointment by Paperflower Psychiatry, LLC unless otherwise agreed on in writing by the provider.

I understand that if I arrive 10 minutes later than my appointment time, I will need to reschedule my appointment. This includes technical difficulties.

I understand that I am expected to trial my microphone and camera prior to my appointment.

I understand that I am expected to notify the support team if I am anticipating being late to an appointment as soon as possible.

I understand that there are no refunds for any reason including but not limited to; no-show appointments, appointments that are cut short due to technology or dissatisfaction with appointment.

I understand that if I choose or require transfer of psychiatric care, I will notify Paperflower Psychiatry LLC as soon as possible to receive a bridge of medication if necessary.

I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer or phone that is used for telepsychiatry. I

understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

I understand that I will inform my provider at Paperflower Psychiatry, LLC if I am at risk to self or others.

I agree that I will go to my primary care doctor or specialists for any medications other than psychotropic medications.

I understand my psychiatric provider cannot provide any medications that are not due to psychiatric purposes.

I agree that I will not share my medication with anyone else.

I agree that I will not receive other psychiatric medications from other providers without first informing my Paperflower Psychiatry, LLC psychiatric provider.

I also understand alcohol and other drugs may compromise my treatment and make my symptoms worse. Paperflower Psychiatry, LLC recommends I abstain from these substances while in treatment.

I may be asked during treatment to provide a urine drug screen, and I will abide by this in order to continue treatment.

Payment, Insurance and Fees

We are a fee-for-service company, and do charge fees for paperwork, medical record requests and time outside of appointments. Updated fees can be found on services page. We use an external billing company to submit claims and verify benefits.

Payment is expected in full prior to service for all online visits. You agree that you will pay in full and are responsible in full for payment. If insurance denies the visit for telehealth treatment, you agree that you will be responsible for the full cost of the visit. Fees per self pay visit are:

$250 per evaluation
$100 per follow up

All payment must be received before the scheduled appointment. Not paying prior to the appointment will mean that your appointment will be rescheduled or cancelled.

You are required to have a debit/credit card on file to maintain your appointment.

A $1 charge will be made to your card to ensure it works prior to your visit. This will be deducted from any future balances or refunded if no copays or deductibles apply. You agree that this $1 will be made upon booking an appointment for services.

You are required to have a credit/debit in addition to any FSA/HSA card on file. You can request to have your HSA charged first. If there is no money loaded 24 hours prior to your appointment on your HSA/FSA card, your credit card will then be charged.

All fees/copays/deductibles are collected 24 hours prior to your appointment.

If your payment does not go through prior to the appointment and you have not made other arrangements with support (to update card, a day you get paid, payment plan etc), your appointment will be canceled.

If insurance information is not submitted in a timely manner as to verify insurance benefits, a $200 hold for evaluations and a $100 hold for follow ups will be placed on your card. Refunds will be provided if appropriate after benefits are verified.

If you do not have updated insurance information within 24 hours of your appointment, that visit may be charged as a self pay rate.

Refunds are not issued in any circumstance if the service has already taken place. No refunds will be provided for any reason including if the service has already been initiated through telepsychiatry video or if you have entered the practitioner's office at Paperflower Psychiatry, LLC.

A sliding scale is arranged with a single provider. If you chose care with another provider, you may be subject to the full fee unless otherwise arranged. Please contact support if you have questions on this.

Paperflower Psychiatry, LLC is not responsible at this time for submitting superbills or any reimbursement forms to your insurance company. You will be provided the superbill to submit upon request.

Paperwork including but not limited to FMLA, ESA letters, and disability will require a fee prior to completion as to respect the time of the provider.

Refusal to create and abide to a payment plan within 90 days of your visit will result in your bill going to collections will may affect your credit score. An additional fee of $200 will be added on in order to compensate this LLC for collections fees.

No Show Policy

A "no show" constitutes as not attending your appointment, cancelling your appointment under 24 hours prior to your appointment time (even emergencies...sorry :-(), attending your appointment while driving or coming to your appointment 10+ minutes late.

A no show fee for an evaluation is $100 if rescheduled and attended, or $250 if choosing to not reschedule

A no show fee for a follow up is $100, even if on a sliding scale

No show fees need to be paid or put on payment plan prior to your next visit

Medication

During my initial appointment your provider will discuss medications that can be used in treatment along with potential side effects of these medications. Your provider will also discuss what to do if experiencing any side effects.

After your provider sends a medication, you are required to call the pharmacy to troubleshoot any insurance, quantity, or other concerns prior to contacting us. DO NOT DEPEND ON YOUR PHARMACY APP TO TELL YOU IF WE SENT A MEDICATION - more often than not, we sent it! Call your pharmacy if it says the medication isn't ready (it probably has nothing to do with us.

Medications other than psychiatric medications will not be provided by us.

Medications can only be sent to pharmacies in the state of Arizona unless your provider holds an alternative state license.

Your provider may require cardiac clearance at any time prior to initiation or refill of medication if indicated.

If you need to change a pharmacy after a medication is sent due to quantity or other concerns, you are able to request your pharmacy to directly submit a change.

If you need the provider to resend the medication to another pharmacy after your medication has already been sent, please note that can take 72 business hours. This may take longer for controlled substances due to federal regulations.

Medications that require blood work such as mood stabilizers are not guaranteed to be refilled unless blood work has been completed and follow up appointments are completed as requested by the provider.

We will not prescribe psychiatric medications if you choose to have two psychiatric providers - this is not a safe arrangement.

You may be requested to sign a "controlled substances" policy if prescribed a stimulant or other controlled medication.

You understand that prior authorization requests can take 5-7 business days to complete.

Controlled substances such as Adderall and Ritalin may require at least one in-person visit per year. This has been waived during the time of COVID at this time. However, if the law changes, you will be responsible to visit one of our offices to complete this requirement.

We will not prescribe benzo's (xanax, ativan, etc) unless it is
(1) for a short term situation such as a flight/funeral/etc
(2) you come in already taking one and create an agreement with your provider to taper from it

Refills

Medication refills are completed during appointment visits. It is my responsibility to schedule a follow-up visit within the agreed upon timeframe discussed during my appointment.

We recommend scheduling your follow-up appointment when you check-out to ensure that you can be seen at a time convenient for you. During certain times of the year, demand for appointments is higher and last-minute appointments may not be available. If I do not follow-up as recommended, my provider may not refill my medication until the next in-person appointment.

If after a controlled prescription is filled, it is reported to be lost, accidentally disposed of, or in any other means not accessible prior to the follow-up appointment, refills will not be provided.

We require an appointment on file to complete your refill.

We will send you enough pills to get to that appointment.

If you have a balance on your account, you must set up a payment plan with a working credit card on file prior to receiving your refills.

If you cancel or choose to not attend after receiving your refill without rescheduling, you will no longer receive refills until you are able to attend an appointment.

If you have not completed labs as ordered, you may be denied a refill at your provider's discretion.

If after a controlled prescription is filled, it is reported to be lost, accidentally disposed of, or in any other means not accessible prior to the follow-up appointment, refills will not be provided.

If you have not been seen by a provider in the requested time frame for follow up (one month, two months or three months), we cannot send your refill.

Refill requests take up to 72 business hours to complete. Please request in advance.
1) example: requests made on a Friday will be completed by Tuesday
2) example: requests made on a Friday will be completed by Wednesday if Monday is a holiday

Services

Once you have scheduled a psychiatry intake appointment, you understand that you are required to complete the appropriate intake forms, review and sign consent forms and put a credit card on file. You understand that your appointment will be cancelled without all forms turned in and without a working payment card on file 24 hours prior to your appointment.

You understand that if you do not review and sign these forms prior to the start time of your intake appointment, your intake appointment may need to be rescheduled. You understand that signing this consent form and agreement to policies is a requirement for psychiatric treatment at Paperflower Psychiatry LLC. You understand that if you decline to sign these forms, you cannot initiate or continue to receive psychiatric treatment at Paperflower Psychiatry LLC and you will be referred to appropriate outside mental health services.

You understand that your provider may require three months of treatment prior to filling out disability paperwork.

You understand that by your provider submitting paperwork including but not limited to disability, an ESA letter, accommodations and/or FMLA, these requests may not be granted by the institution requiring the paperwork.

You understand that the support team can fax paperwork within a 72 hour period of provider completion. Please plan ahead for these deadlines.

You understand by initiating services, your provider is not required to complete paperwork requested unless they find it clinically appropriate.

Medical record requests will be handled within 30 days of written request.

You agree that Paperflower Psychiatry LLC will not participate in any court cases that include our presence without a prior agreement and signed contract with the agency and your provider at $350+/hour.

You understand Paperflower Psychiatry LLC does not do emergency or crisis care. These situations require calls to CRISIS or 911.

You understand that support team messages (voicemails, texts and emails) will be answered within 72 business hours.

You understand that all phone calls are directed to a voicemail then handled by the appropriate support team member, and not answered live immediately upon calling.

You understand that billing questions may take an additional 7 to 14 business days to have an answer as we coordinate with our outside billing company.

You understand that billing inquiries may be delayed further if incidents related to systematic political changes or healthcare policy changes or insurance concerns occur.

You understand that if you have not been seen in 8 months or longer, we will require a full new evaluation.

You understand that we are required to do our own psychiatric evaluation for every new client and cannot accept an evaluation performed by a practitioner outside of Paperflower Psychiatry, LLC in lieu of our own.

You are allowed to request a second opinion or change providers at any time within Paperflower Psychiatry, LLC without explanation.

Supplements

Purpose of Supplement Recommendations:

I understand that the supplement recommendations provided by my psychiatrist are intended to complement traditional psychiatric treatment and may include vitamins, minerals, amino acids, herbal extracts, or other nutritional supplements. These recommendations aim to address specific nutritional deficiencies or imbalances that may impact my mental health.

Benefits and Risks:

I understand that the benefits of supplement recommendations may include improved mood, reduced symptoms of anxiety or depression, enhanced cognitive function, and overall well-being. However, I acknowledge that there are potential risks associated with supplement use, including adverse reactions, interactions with medications, and the possibility of unintended effects on my health.

Informed Decision:

I have been provided with information regarding the potential benefits, risks, and alternatives to supplement recommendations. I understand that I have the right to ask questions and seek clarification about any aspect of my treatment plan, including supplement recommendations, before providing consent.

Voluntary Consent:

I voluntarily consent to incorporate supplement recommendations into my psychiatric treatment plan. I understand that I have the right to refuse or discontinue supplement use at any time, and I will inform my psychiatrist if I choose to do so.

Confidentiality:

I understand that my psychiatric treatment, including supplement recommendations, will be kept confidential in accordance with applicable laws and ethical guidelines. Information about my treatment will only be shared with authorized healthcare providers involved in my care.

Follow-Up and Monitoring:

I agree to attend follow-up appointments as scheduled to monitor the effectiveness of supplement recommendations and make any necessary adjustments to my treatment plan. I understand that regular communication with my psychiatrist is essential for optimizing my mental health outcomes.

Disclaimers

Paperflower Psychiatry LLC is not liable for confidentiality breaches when they are caused by patient error. You are required to notify your provider if there is another person that can hear your conversation.

If video services are not available due to an unplanned equipment or service malfunction, sessions may occur via telephone based on the discretion of the provider. First time evaluations are never allowed via telephone/auditory only methods.

Results are not guaranteed. We will work our hardest to resolve and help you to heal, but referrals to therapy, lifestyle modifications, cognitive homework, and medication compliance is expected.

This provider reserves the right to not engage in legal services, and if agreed upon, a fee will be negotiated along with limitations within a contract. The fees will cover lost

pay for inability to see patients that day, childcare, and other expenses including time spent preparing for the case, writing and reviewing documents.

If this provider determines that she/he is unable to provide an appropriate level of care within her scope and expertise (due to considerations such as personality disorders, severe eating disorders without effective team in place, severe mental illness, significant hospitalizations or substance abuse concerns), she/he reserves the right to refer you to an appropriate provider. Thirty days of treatment will be provided along until the transfer of care is complete.

The provider reserves the right to require a new evaluation for patients who have not had an appointment in eight consecutive months.

Limits

There are situations where I may be referred off campus to a different psychiatric provider. These may include but are not limited to: neuropsychiatric or developmental testing for conditions including Autism, serious mental illness, cases that may require a higher level of expertise, personality disorders, significant legal concerns, drug and alcohol use disorders or dual diagnosis.

Boundaries are imperative. While you may contact the provider or support staff, be aware that they will only reply during business hours. You will have a response as soon as possible which may be 24-72 business hours after your initial contact.

Your provider may be out of office and will return communication as soon as available. You agree to call 911 or crisis for emergencies. Paperflower Psychiatry, LLC does not provide on-call services for emergencies.

If your provider is out of office, you may obtain coverage for appointments by another provider contracted by Paperflower Psychiatry, LLC.

Telepsychiatry may not be appropriate for patients with active suicidal thoughts, homicidal thoughts or patients who are experiencing acute mental health problems requiring frequent hospitalizations.

Paperflower Psychiatry LLC does not provide urgent, emergency, crisis or inpatient care. If you are experiencing an acute crisis and feel you may be a danger to yourself or others, please go to the nearest emergency room, call 911 or your local crisis hotline. The national crisis hotline number is 1-800-273-TALK.

If through the initial evaluation or subsequent sessions, a patient is deemed to be at active risk of harm to self or to others, Paperflower Psychiatry LLC will terminate the sessions, while providing alternative treatment options and referrals which may include inpatient treatment.

Results are not guaranteed. We will work our hardest to resolve and help you to heal, but referrals to therapy, lifestyle modifications, cognitive homework, and medication compliance is expected.

For pediatric appointments, all truthful information regarding custody and decision making is expected to be disclosed prior to the evaluation. This provider reserves the right to reschedule or cancel the appointment without refund if custody arrangements are not disclosed and abided by.

The person who enrolls the child should bare all responsibility, not Paperflower Psychiatry LLC, if they are untruthful about legal decision making, custody or guardianship.

For pediatric appointments, the legal guardian is expected to be present for the duration of the appointment. Unless otherwise arranged, the pediatric patient needs to be present for the appointment.

For pediatric appointments, the provider may request to meet with the child or adolescent privately or without the guardian present for purposes of the clinical interview.

Calls will only be returned within business hours.

Emails will be responded to within business hours.

Appointments run throughout the day, and emails and text messages will be answered accordingly as soon as possible.

Termination of Care

This provider reserves the right to terminate care and immediately refer outside of the practice for misuse of medication, patients outside of expertise level or misconduct. This includes vulgarity, threats or acts of physical or verbal aggression to the provider and/or support staff. I adhere to acting in a courteous and respectful manner in all interactions. Harassment, verbal aggression or threats of any sort will not be tolerated and will lead to immediate termination of care.

Grounds for discharge includes:

- Refusal to work with our support team or any disrespectful, racist, vulgar language toward our support team.
- Choosing to have another provider fill or change your psychiatric medications without first notifying your Paperflower provider
- Dishonesty in regards to, selling or misusing medication prescribed
- Failing to show up (or a "no show") 3+ times for your appointments

- Refusal to follow treatment plan of my psychiatric provider
- Refusal to create a payment plan for balances due
- Avoidance of bills and refusing payment
- Refusal to maintain a credit card on file
- Not taking medications as prescribed
- Refusal to follow up as recommended by your provider
- Disrespect, harassment or vulgar language towards your provider
- Dishonesty in regards to custody situations or legal matters
- A patient outside of our expertise or scope of practice
- Discomfort of treatment or other unspecified reasons
- Refusal to abide by the terms agreed to in this consent form

In cases of discharge, we will send three referral sources for a new provider and a 90 day supply of medication if the medication is noted by provider to be safe to refill.

Emergencies

Is this an active emergency? If so, please go to the nearest ER or call 911. DO NOT call the provider.

Is this a crisis situation in which your child is currently aggressive, escalating and you feel in danger being near them? Please call crisis at 602-222-9444. The provider cannot help de-escalate the situation. This is best done by experts on a Crisis Team.

Release and Waiver

I hereby willingly, free from duress, release, waive, and forever discharge any and all liability, claims, and demands of whatever kind or nature against Paperflower Psychiatry LLC and its affiliated partners and sponsors, including in each case, without limitation, their directors, contractors, officers, employees, volunteers, and agents (the "Released Parties"), either in law or in equity, to the fullest extent permissible by law, including but not limited to damages or losses caused by the negligence, fault, or conduct of any kind on the part of the Released Parties, including but not limited to death, bodily injury, illness, economic loss, or out-of-pocket expenses, or loss or damage to property, which I, my heirs, assignees, next of kin, and/or legally appointed or designated representatives, may have or which may hereinafter accrue on my behalf, which arise or may hereafter arise from my participation with the in-person or Telehealth office visit or activity.

Acknowledgement and Consent

I have read this description of services and understand and consent to all stated policies. I understand and agree to my patient responsibilities and understand my

patient rights. I understand that I have an opportunity to discuss my questions regarding the psychiatric treatment services with Paperflower Psychiatry LLC. I understand that there are potential the risks and the benefits to associated with the psychiatric treatment services on a telepsychiatry platform. I have the right to make decisions about the psychiatric treatment services I receive, to refuse the psychiatric treatment services and to revoke this consent at any time except to the extent services have already been provided. Based on the information I have received, I consent to the psychiatric treatment services at the Paperflower Psychiatry LLC.

I acknowledge that I am responsible for payment of psychiatric services received, and I understand the billing procedures of Paperflower Psychiatry, LLC. I authorize the release of necessary information to process insurance claims.

By clicking below, you confirm you have read the above and agree to these terms and conditions and consent to treatment. You acknowledge that you agree to the policies and have received and reviewed all information above.

If you are signing as a guardian, you are acknowledging that you consent to treatment on behalf of your child. You acknowledge that you are the legal guardian of your child, and are truthful to Paperflower Psychiatry, LLC about current legal rights that may have been made in court regarding medical decision making. You acknowledge that you agree to the policies and have received and reviewed all information above.