Consent form for Neurodivergence testing

Please confirm the following before booking your appointment. We cannot refund you for not reading or understanding the following after you have signed this form.

BY BOOKING THIS APPOINTMENT, I UNDERSTAND AND CONSENT TO THE FOLLOWING:

I understand that by being assessed by a nurse practitioner in the state of Arizona, my diagnosis will not qualify for ANY benefits or services from the Division of Developmental Disabilities (DDD).
A diagnosis that qualifies for DDD benefits/services is required to be given by: a psychologist, a psychiatrist (MD), or a developmental pediatrician.
I understand that by booking this evaluation, I am not guaranteed to have a diagnosis of ADHD or Autism, and the provider will give me the diagnosis they feel is most accurate.
I understand that this evaluation does not establish me as a patient of Paperflower Psychiatry, and this evaluation is strictly diagnostic. This evaluation does not include the prescription of medication, but only written recommendations.
I understand that FMLA, disability or other forms of paperwork will not be completed during or after this evaluation by the provider evaluating me as part of the evaluation cost.
I understand if I want to establish myself as a Paperflower Psychiatry patient before or after my evaluation, I can contact the support team at support@paperflowerpsychiatry.com to discuss insurance and follow up appointments in which medication can be discussed.
I understand that even if established as a patient of Paperflower Psychiatry, paperwork is an additional fee to complete and my provider is allowed to refuse any paperwork they do not feel comfortable completing.
I understand that this evaluation requires payment upon booking and will not be covered or reimbursed by insurance.
I understand that a diagnosis provided to me will not guarantee services to be approved or pre-approved by my insurance company.
I understand all appointments for the evaluation will be in person, and the follow up will be via Telehealth unless otherwise specified by my provider.
I understand I cannot be fully refunded in **any** situation including urgent, emergent, or unforeseen circumstances if I do not or can not attend my appointment.
I understand this only tests for Autism Spectrum Disorder and ADHD, and does not include intelligence, cognitive or any other psychological testing.
I understand and consent that the full no-show fee for my appointment is $350 and the remainder would be refunded to me within 10 business days.
I understand the only way I can have a refund is if I cancel over 24 hours before the appointment time.
I understand I cannot be refunded if I do not agree with the outcome of the evaluation.
I understand I have the right to terminate my appointment during the visit.
I understand if I terminate my appointment during my visit, I cannot be refunded.
I understand that if I provide my report to other providers outside of or within Paperflower Psychiatry, they are allowed to disagree with my diagnosis.
I understand I am allowed to request to submit a grievance against my provider to our practice manager at delfina@paperflowerpsychiatry.com and will fill out the requested form for review.

HIPAA Acknowledgement, Continued Consent Form, Patient Rights

Please read carefully sign where indicated.

Evaluation Information :
I, the undersigned, hereby consent to a neurodivergence evaluation provided by Paperflower Psychiatry, LLC. I understand that this means that I will be evaluated for ADHD and Autism Spectrum Disorder, but this is not a full diagnostic psychiatric evaluation. I understand I may be offered rule out diagnoses if I do not meet criteria for ADHD or Autism Spectrum Disorder.
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 my evaluation, I will be offered a report including recommendations for supplements, therapy techniques, possible medications, and lifestyle changes. I understand no medications will be prescribed during this evaluation process or follow up.
Purpose of Treatment:
While the benefits of the evaluation are easily recognized, the risks, there are inherent risks and limitations. These may include:

- Miscommunication
- Not receiving the diagnosis or answers you are hoping for
- Receiving an unexpected diagnosis
- Not enjoying the evaluation process

• Emotional discomfort during the evaluation process
• Unforeseen challenges during the evaluation
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

In-person appointment.

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 for 7 years.

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

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 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 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.
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 15 minutes later than my appointment time, I will need to reschedule my appointment without refund. 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 if I need a refund to change cards (credit card to HSA, etc.) a 6% service charge will be added.
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 understand that the Neurodivergence evaluation does not establish me as a patient of Paperflower Psychiatry, and I will not be prescribed medications during this process.
Payment, Insurance and Fees
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.

$2,000 for the full evaluation is due in the following increments:
Prior to first appointment: $600
Prior to second appointment: $600
Prior to follow up/report: $400
I understand that I will not receive the report or any diagnosis if I do not finish or complete payment for the full evaluation process, and I will only be able to request the record of the notes taken from the provider.
All payment must be received before the scheduled appointment. Not paying prior to the appointment will mean that your appointment will be rescheduled or canceled.
You are required to have a debit/credit card on file to maintain 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.
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.
Sliding scales will require a contract including documentation of income and financial hardship. Contracts are specific to one provider only, and are not applied if you switch providers.
No Show Policy
A "no show" constitutes as not attending your appointment, canceling your appointment under 24 hours prior to your appointment time (even emergencies...sorry :-(), attending your appointment while driving or coming to your appointment 15+ minutes late.
A no show fee for an evaluation is $350. A no show fee for the final follow up is $150. These will be consistent for sliding scale patients as well.
No show fees need to be paid prior to rescheduling.
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 canceled 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 and a no show fee will be required.

You understand that signing this consent form and agreement to policies is a requirement for an evaluation at Paperflower Psychiatry LLC. You understand that if you decline to sign these forms, you cannot initiate an evaluation at Paperflower Psychiatry LLC and you will be referred to appropriate outside mental health services. 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 $700+/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 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.

Supplements

Purpose of Supplement Recommendations:

I understand that the supplement recommendations provided by my psychiatric provider 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 or medication 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. Appointments 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.

Limits

There are situations where I may be referred off campus to a psychologist for full testing.

I will not be tested for learning disabilities, auditory processing disorders, or any other diagnoses other than ADHD and Autism Spectrum Disorder. I may be given rule out diagnoses which would require further follow up with another specialist or provider.

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.

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.

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 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, sexual harassment or threats of any sort will not be tolerated and will lead to immediate termination of care.
Grounds for discharge without refund includes:
• Refusal to work with our support team or any disrespectful, racist, vulgar language toward our support team.
• Refusal to create a payment plan for balances due
• Avoidance of bills and refusing payment
• Refusal to maintain a credit card on file

- Disrespect, harassment or vulgar language towards your provider
- Dishonesty in regards to custody situations or legal matters

• Discomfort of treatment or other unspecified reasons
• Refusal to abide by the terms agreed to in this consent form
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 evaluation services with Paperflower Psychiatry LLC. I understand that there are potential the risks and the benefits to associated with the evaluation services on a telepsychiatry platform. I have the right to make decisions about the services I receive, to terminate the evaluation, 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 evaluation services at the Paperflower Psychiatry LLC.

I acknowledge that I am responsible for payment of services received, and I understand the billing procedures of Paperflower Psychiatry, LLC include a credit card on file.

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

_____ _____

Name Date