Mindwaves

New Patient Demographic Information -Adult

Patient Name: _____

Sex: M_____F ____Non-binary_____ Your Pronoun: He_____ She_____ They/them_____

Address:_____

Phone: Home:_____Cell: _____Work:_____

Email:_____

DOB: _____/_____/_____ Marital Status: Single____Married____Separated_____Divorced ____

☐ By checking this box, I agree to receive SMS text messages from Mindwaves Mental Health at the phone numbers provided above. The SMS frequency may vary. Data rates may apply. Text HELP to 470-826-2233 for assistance. Reply Stop to opt-out of receiving SMS messages.

Emergency Contact:

Name:_____

Relationship: _____Phone: _____

Medical History:

Physician Name:_____ _____

Address:_____

Phone:_____

Current medical problems:_____

Current MedicaMons:_____

Allergies:_____

Past Psychiatric History:

Past Diagnosis:_____

Past Treatment History: _____

Past MedicaMons Trial:_____

Substance Abuse History:_____

History of hospitalizaMon:_____

Billing Responsibility:

If you are paying out of pocket, initial this line:_____

Primary Insurance Holder Name:_____

Member ID#:_____

Primary Insurance Holder DOB:_____/_____/_____

Primary Insurance Holder Address:_____

Briefly describe why you are seeking psychiatric evaluation:

_____

_____

_____

_____

_____

Mindwaves

Consent to Treatment

Welcome to Mindwaves Mental Health. This statement provides important information about the services that we provide, our policies and procedures, and your rights and responsibilities as a patient. Please read this document thoroughly and be sure to raise any questions or concerns as soon as possible.

1. About Mindwaves Mental Health

Mindwaves Mental Health is a medical practice that specializes in psychiatric, psychological, behavioral, and mental healthcare.

We make every effort to use the most advanced and appropriate evidence-based interventions.
If we are not able to provide the care that you need, we will provide you with referral information. We do not discriminate against any individual based on race, color, gender identification, ethnicity, religion, sex, age, national origin, sexual orientation, or socioeconomic status.

2. Nature of Our Services

To begin with, we will meet with you for an initial consultation, which may take place over one or more visits. This consultation will help determine the nature of your symptoms, concerns, and difficulties, as well as whether the services that we provide are appropriate for your needs. If you have a current treatment provider, we may ask for written consent to speak with that person if it is likely to help in making assessment or treatment decisions for your care. The fee for this evaluation is detailed in the “Fees and Payments” section below.
After the consultation, we will give you feedback, make recommendations for further services, and describe various treatment options that may be the best fit for your needs. If you are offered services through Mindwaves Mental Health, we will describe what will be required of you, what you can expect in treatment, and address any concerns or questions you may have. You may request referrals at any time during the treatment process if you do not feel our services are a good fit for you. We encourage you to bring up any questions or concerns during the treatment process, as many issues can be problem-solved effectively together. You are free to withdraw from treatment at any time.
If you accept treatment with Mindwaves Mental Health, your fee will be set based on the standard applicable fees, unless otherwise stated (see Section 7 below). Your personal information will be stored confidentially using HIPAA- compliant electronic medical record software. The measures that we take to protect the privacy and security of your confidential medical information is more fully described in Section 4, below, and in our Notice of Privacy Practices.

3. Your Treatment Sessions

The **initial consultation** session will last between ttt-ti0 minutes. Subsequent consultation sessions may be necessary based on your needs and our discretion.
At the conclusion of the consultation, we will provide you with a formal recommendation for treatment.

So that you can receive the maximum benefit from treatment, we are likely to recommend that you receive scheduled sessions weekly. Depending on our assessment, and on your availability, alternate schedules may be discussed.

A **standard session** is usually scheduled for 1t- ti0 minutes depending on your treatment modality.

4. Your Rights and Our Responsibilities

A. Confidentiality

With the exception of certain specific exemptions described below, you have the right to the confidentiality of your treatment.

We will not tell anyone else what you have told your Mindwaves Mental Health provider, or even that you are in treatment with Mindwaves Mental Health, without your prior written permission. (Under the provisions of the Health Care Information Act of 1992, we legally may speak to another health care provider or a member of your family about you without your consent, but, except in an emergency situation, we will always ask for your consent first.)
You may direct Mindwaves Mental Health to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to a3end a treatment session with you. Of course, we cannot promise that the person whom you invited will maintain your confidentiality.

If another healthcare provider is working with you and you would like us to communicate with that individual/group, Mindwaves Mental Health will ask you to sign a wri3en authorization before we disclose your protected healthcare information. If your child is our patient, then (with certain exceptions including emancipated minors, mature minors, and minors receiving treatment for substance abuse), you have a right to all information discussed in sessions and clinical records. Authorizations to disclose a child's protected healthcare information must be signed by a parent or legal guardian.

You are also protected under the provisions of the Health Insurance Portability and Accountability Act (HIPAA). This law ensures the confidentiality and security of your protected health information about you. Whenever we transmit protected healthcare information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to ensure confidentiality.

If you wish to communicate with MINDWAVES MENTAL HEALTH by email at some point in our work together, among other things, all emails are retained in the logs of your and our internet service providers. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email that we receive from you, and any responses that we send to you, will be kept in your treatment record.

In order to send and receive communications with MINDWAVES MENTAL HEALTH by email, you will be required to sign a separate "TCPA" consent.

The following are some of the legal exceptions to your right/your child's right to confidentiality. If possible, we will inform you before we disclose your information in these situations:

• If we have reason to believe that you may make a serious and/or imminent attempt to harm

another person, Mindwaves Mental Health is required by law to notify relevant emergency personnel, and to attempt to inform the potential victim and warn them of your intentions. • If we have reason to believe that you are abusing or neglecting a child or vulnerable adult, if the patient is an abused or neglected child or vulnerable adult, or if you give us information about someone else who is perpetrating or suffering such abuse, Mindwaves Mental Health must inform Child Protective Services or Adult Protective Services immediately.

• If we have reason to believe that you may make a serious and/or imminent a3empt to harm another person, MINDWAVES MENTAL HEALTH is required by law to notify relevant emergency personnel.

• If you initiate legal action or ethical charges against MINDWAVES MENTAL HEALTH, we may disclose certain information as part of defending against such lawsuit or charges.
Additional detail is provided in our Notice of Privacy Practices.

B. Record-keeping.

Mindwaves Mental Health keeps records electronically on a HIPAA-compliant platform. We will maintain any paper records in a secure location that cannot be accessed by anyone else. Under HIPAA, you have the right to a copy of your file at any time. You have the right to request that we correct any errors in your file. You have the right to ask that we make a copy of your file available to any other health care provider at your wri3en request.

C. Diagnosis

If a third party such as a private insurance company is paying for part of your bill, we are normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If we do use a diagnosis, your clinician will discuss it with you. All of the diagnoses come from a book entitled the ***DSM-V;*** we have a copy in our offices and will be glad show it to you so that you can learn more about what it says about your diagnosis.

D. Other Rights

You have the right to ask questions about anything that happens in treatment. Our clinicians are always willing to discuss how and why they've decided to do what they are doing, and to look at alternatives that might work be3er. You can feel free to ask your clinician to try something that you think will be helpful. You can ask MINDWAVES MENTAL HEALTH about your clinician's training for working with your concerns and can request that we refer you to someone else if you decide that your MINDWAVES MENTAL HEALTH clinician is not the right fit for you. You are free to leave treatment at any time.

5. Our Approach to Treatment; Termination of Treatment

Treatment with our staff may involve medication and sometimes touching upon thoughts, emotions, or that are challenging or difficult for you. However, you have the right to refuse anything that we suggest.

You should be aware that approaching problematic feelings or thoughts may be painful. Making changes in how you handle your thoughts, feelings, or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find that your relationship with your clinician to be a source of strong feelings, some of them painful at times. But these risks may be worth the changes and benefits that you experience. It is your decision whether to take these risks.

You normally will be the one who decides with your clinician when your treatment will end, with three exceptions: 1) If we have contracted for a specific short-term piece of work, we will finish treatment at the end of that contract. 2) If our staff are not (in our judgment) able to help you/your child because of the nature of the problem we will inform you of this fact and refer you to another clinician or program that may meet your needs. 3) If you do violence to, threaten verbally or physically, or harass our staff, the office, or our families, we reserve the right to terminate you unilaterally and immediately from treatment. If we terminate your treatment, we will offer you referrals to other sources of care but cannot guarantee that they will accept you for treatment.

Sometimes your clinician may be away from the office several times in the year for extended travel or to attend professional meetings. Your clinician will tell you well in advance of any anticipated lengthy absences. By case-by-case agreement, staff is available for brief between-session phone calls during normal business hours. If you are experiencing an emergency when your clinician is out of town, or it is outside of regular office hours (after t pm weekdays or over the weekend), please call 911, or go to the nearest hospital emergency room for assistance.

6. Your Responsibilities as a Patient

You are responsible for coming to your session on time and at the time we have scheduled. You must pay for your session weekly, unless we have made other firm arrangements in advance. If you are late, we will end on time and not run over into the next person's session.
If you need to miss a session, you must provide tt8 business hours' notice. If you fail to let us know, or cancel with less than forty-eight hours' notice, you must pay a cancellation fee for that session prior to our next regularly scheduled meeting. The only exception to this rule are if there is a weather event that causes Boston Public Schools to close, or if you or someone whose caregiver you are has fallen ill suddenly.

7. Fees and Payments

Please ask our administrative staff for our current fee schedule for your clinician. You agree to pay all legal fees if your provider is subpoenaed regarding your care.
Fees are subject to change. If our fees change, we will alert you to the change at least thirty days in advance. You authorize us to submit the required information regarding your medical services to your insurance carrier for payment.

We accept various types of private insurance and Medicare. In such cases, you will be required to pay the out of pocket expenses.

If you do not have insurance that we accept, we will provide (at your request) a "super bill" to allow you to seek out-of-network reimbursement from your insurer. We do not guarantee that any portion of the fees will be reimbursed by your insurance provider. If your insurance provider does not reimburse for your services for any reason, you will remain responsible for paying the full amount of the fees for our services.

You are responsible for paying your portion of our fees at the time of service.

We accept payment by cash, check or credit card, which we can keep on file with you with your consent. We will send you a bill periodically for any missed payments, missed sessions, and miscellaneous services provided outside of your sessions. If a credit card is on file, your payment will be made automatically.

8. Complaints

If you're unhappy with what is happening in your treatment, we hope you'll talk about it with us so that we can respond to your concerns. We will take your concerns seriously, with care, and with respect.

Signature on Next Page

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Patient Consent to Treatment: Please read below and provide your signature.

I have read this Consent to Treatment in its entirety. I have had sufficient time to consider it carefully, I have asked any questions that I needed to, and I understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to the release of that information and other information necessary to complete the billing process. I agree to pay the fee for services at the time of service, and for any missed sessions or late cancellations. If my insurance provider fails to reimburse any portion of the fees for the services I have received, I understand and agree that I will be responsible for paying the unpaid portion of the fees.

I understand my rights and responsibilities as a patient, and my clinician's responsibilities to me. If my child is the patient, I understand that the rights and responsibilities also pertain to him/her. I agree to undertake treatment for myself/for my child with Massachuse3s Mind Center. I know I can end treatment at any time I wish and that I can refuse any requests or suggestions made by providers. I am over the age of eighteen or am an emancipated minor.

_____	_____	_____
Date	**Patient name (please print)**	**Signature**

If the patient is less than 18 years old:

I am the parent or legal guardian of the patient named above. I fully understand all information and terms contained in this Consent to Treatment, and on the patient's behalf, I consent to all the terms set forth herein (which shall apply either to me or to the patient, as context requires.)

_____	_____
Signature of Parent/Legal Guardian	**Name of Parent/Legal Guardian (please print)**

_____

Relationship to Patient

P: 470-826-2233 | F: 470-826-2233 | E: contact@mymindwaves.com
855 Peachtree St NE, Suite 3401, Atlanta, GA 30308 | mymindwaves.com

Mindwaves

Authorization to Use and Disclose Protected Health Information

Patient name: _____ Date of Birth: _____

I. DISCLOSING HEALTH INFORMATION

By signing this Authorization, I am authorizing Mindwaves Mental Health, LLC (the "Practice"), to use, disclose, obtain, and release any and all of my Personal Health Information (defined below), whether written or verbal, including without limitation psychiatric and psychological records.

The information covered by this authorization (the "Personal Health Information") includes all information that identifies me that relates to my diagnosis, treatment, payment, criminal record information, healthcare services, continuing care plans, demographic information, treatment progress, and assessment. Among other things, it includes all information that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines as Protected Health Information.

Persons to Whom the Practice is Authorized to Disclose My Personal Health Information

I hereby authorize the Practice to disclose my Personal Health Information to, and obtain my Personal Health Information from, the following persons/organizations/categories:

Person/Organization	Location/Contact
Primary Care Physician	[Please fill in, if known]
Previous/other Psychiatrist:	[Please fill in, if known]
Previous/other therapist:	[Please fill in, if known]
School Contact:	
Family Member:	
Other:	

II. SCOPE OF DISCLOSURE

Unless I have specifically requested in writing that the disclosure of information be made in a certain format, I understand and agree that the Practice reserves the right to disclose information as permitted by this authorization in any manner that it deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

The health information that may be used, disclosed, or obtained through this Authorization is as follows (select A, B):

A. □ **The following specific health information** (check all that apply):
□ Medical record (history & physical, discharge summary, lab reports, imaging reports, consults)
□ Psychotherapy and Psychiatrist records
□ Substance Abuse Assessment & Treatment
□ HIV, STD disease test results
□ School records (specify school and type of record): _____
□ Other records (specify content): _____

B. □ **All health information about me, except the following**:_____

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III. PURPOSE OF DISCLOSURE

The purpose of the disclosure is:

□ Coordination of treatment, assessment, improving health care operations, and/or assisting in billing for payment of services

□ Other (specify):_____

This Authorization expires:

□ At termination of my treatment with the Practice **OR**

□ (Specify date or event): _____ **OR**

□ Six months from the date of my signature

MY RIGHTS

1. I understand that provider abides by the rules of HIPAA Federal Confidentiality Regulations (42 CFR Part 2), which protects the confidentiality of my medical record and that information contained in my record cannot be disclosed without my consent unless otherwise provided for in the Regulations or by statute.
2. Authorizing the disclosure of this health information is voluntary, and I have the right not to sign this document. The Practice will not condition my treatment or payment on my providing authorization for the requested disclosure.
3. I understand that I may revoke this Authorization in writing at any time by sending an email to contact@mymindwaves.com. I understand that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before the Practice receives written notice of revocation.
4. I have the right to make a written request to review my records before signing. I have the right to receive copies of my records for a reasonable fee.
5. I have a right to a copy of this signed authorization.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. By my signature below, I hereby knowingly and voluntarily authorize the Practice to use, disclose, and/or obtain my Personal Health Information in the manner described above.

Signature of Patient: _____ Date: _____

_____

If the Patient is an unemancipated minor or otherwise incapacitated (physically or mentally):

_____ _____

Signature of Parent/Guardian Date

_____

Description of Authority or Relationship

Mindwaves

INFORMED CONSENT FOR TELETHERAPY

This Informed Consent for Teletherapy contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let your clinician know if you have any questions. When you sign this document, it will represent an agreement between you and Mindwaves Mental Health.

Benefits and Risks of Teletherapy

Teletherapy may include psychiatric, psychological, behavioral, or mental healthcare that is provided remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of teletherapy is that the patient and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the patient or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits of teletherapy, there are some differences between in-person psychotherapy and teletherapy, as well as some risks. For example:

● *Risks to commensality.* Because teletherapy sessions take place outside of Mindwaves Mental Health's private offices, there is potential for other people to overhear sessions if you are not in a private place during the session. On our end, we will take steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. Please participate in therapy only while you're in a room or area where other people are not present and cannot overhear the conversation.

● *Issues related to technology.* There are many ways that technology issues might impact teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

● *Crisis management and intervene-on*. Usually, we will not engage in teletherapy with patients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.

● *Efficacy.* Most research shows that teletherapy is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of teletherapy service to use. You may need certain computer or cell phone systems to use teletherapy services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in teletherapy.

Depending on your method of connection to teletherapy, your cellular or mobile telephone provider may charge you according to the type of plan you carry. You are solely responsible for all such charges.

For communication between sessions, we only use email communication and phone messaging with your permission (under a separate written agreement) and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with our office should be limited to administrative matters. This includes things like scheduling and changing appointments, billing matters, and other related issues. You should be aware that we cannot guarantee the confidentiality of any information communicated by email or text. Therefore, we will not discuss any clinical information by email or text and prefer that you do not either. In addition, email and text messages **should not** be used if there is an emergency. Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to make contact by phone. We will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach your clinician and feel that you cannot wait

for return call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your clinician will be unavailable for an extended time, we will provide you with the name of a colleague to contact if necessary.

Confidentiality
We have a legal and ethical responsibility to make our best efforts to protect all communications that are a part of our teletherapy. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for teletherapy sessions and having passwords to protect the device you use for teletherapy).

The extent of confidentiality and the exceptions to confidentiality that we outlined in the Consent to Treatment and Notice of Privacy Practices still apply in teletherapy. Please let us know if you have any questions about exceptions to confidentiality.

Appropriateness of Teletherapy
From time to time, if possible, we may schedule in-person sessions to “check-in “with one another. We will let you know if teletherapy is no longer the most appropriate form of treatment for you. If you ever feel that teletherapy is unsatisfactory or inappropriate, please let us know. You and we would then discuss options of in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. To address some of these difficulties we will create an emergency plan before engaging in teletherapy services. We will ask you to identify an emergency contact person who is near your location and who we will contact in the event of a crisis or emergency to assist in addressing the situation. We will ask that you sign a separate release of information form allowing us to contact your emergency contact person as needed during such a crisis or emergency. If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call back; instead, call 911, or go to your nearest emergency room. Call back after you have called or obtained emergency services. If the session is interrupted and you are not having an emergency, disconnect from the session and we will wait two (2) minutes and then re-contact you via teletherapy platform on which we agreed to conduct therapy. If you do not receive a callback within two (2) minutes, then call back on the phone number that we provide you. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees
The same fee rates will apply for teletherapy as apply for in-person psychotherapy. As with in-person psychotherapy, we accept reimbursements from certain private insurance payers, and Medicare. If you have insurance that we do not accept, you may seek out-of-network benefits from your insurer. But whether or not you have an insurance plan that we accept, and whether or not your insurer provides reimbursement, you are ultimately responsible for paying the entre fee. It is important to know that your insurance may not cover sessions that are conducted via telecommunication. We strongly encourage you to contact your insurance provider to find out whether and under what conditions your teletherapy is a covered service.

Records
We will maintain a record of the session in the same way we maintain records ofin-person sessions. The teletherapy sessions shall not be recorded in any way unless agreed to in writing by mutual consent.

Mindwaves

Consent to Treatment

This agreement is intended as a supplement to the general Consent to Treatment, a separate document that you agree to at the outset of our clinical work together. This document does not amend or change any of the terms of that agreement.

Your signature below indicates that you have read and agree to this Informed Consent for Teletherapy document and agree to abide by its terms during our professional relationship.

_____ _____

Signature of Patient Date

If the Patient is an unemancipated minor or otherwise incapacitated (physically or mentally):

_____ _____

Signature of Guardian/Personal Representative Date

_____

Description of Authority or Relationship

P: 470-826-2233 | F: 470-826-2233 | E: contact@mymindwaves.com
855 Peachtree St NE, Suite 3401, Atlanta, GA 30308 | mymindwaves.com

Mindwaves

Patient Payment

Mindwaves Mental Health (“MMH”), accepts payment through debit, or credit card. We require that all patients agree to pay all bills in a timely fashion (in accordance with the payment terms set forth in the Consent to Treatment and other documents), and provide a credit or debit card on file to be used as a primary method of payment or as a backup payment for late or outstanding bills.

If the patient is less than 18 years old, we require that a parent or legal guardian of the patient agree to pay the patient’s bills in a timely fashion, and provide their credit or debit card to be used as a primary method of payment or as a backup payment for late or outstanding bills provided to the minor patient.

Appointment Cancellation and No-Show Policy
At Mindwaves Mental Health Services, we reserve our providers’ time specifically for you to ensure you receive the care and attention you deserve. If you need to cancel or reschedule your appointment, we kindly ask that you provide at least **48 hours' notice** to allow us to accommodate other patients.

Please note that missed appointments or cancellations with less than 48 hours' notice are not covered by insurance and will result in a **no-show fee of $250**.

We understand that unexpected situations can arise, and we are here to work with you. If you need to make changes to your appointment, please contact us at 470-826-2233 or email us at contact@mymindwaves.com as soon as possible.

Payment Authorization and Agreement

I, the signatory below, agree that I am responsible for all bills resulting from MMH's services for me, that I will pay all such bills in a timely fashion, and that all payment terms set forth above, in the Consent to Treatment, and in any other document governing services and payments shall apply to me.

I agree to submit payment to MMH for the amount due at the beginning of each appointment. If I am enrolled in auto-pay, my card will be processed for the balance on my account and I will receive a statement documenting the services and charges. I understand that I may choose to pay by check and will make this payment to MMH at the beginning of each appointment. I understand that if I do not submit payment by check by the end of an appointment, my card on file will be billed for the amount due and I will receive a statement documenting these services and charges.

I authorize MMH to use my card to bill automatically all Fees incurred pursuant to the Consent to Treatment, or such other fee schedule that we agree on from time to time. If MMH is unable to secure funds from my card for any reason, including, but not limited to, insufficient funds in the card or insufficient or inaccurate information that I provided when submitting electronic payment, MMH may undertake further collection action, including application of fees to the extent permitted by law.

I have the right to revoke this authorization by notifying MMH at least fifteen (15) days prior to the scheduled payment date. I understand and acknowledge that services may be cancelled or withheld if I revoke this

authorization, and that I am still responsible (and my card may be charged) for all fees incurred by me or otherwise owed to MMH. This authorization will remain in full force and effect until revoked by me or MMH.

I acknowledge and agree that I will not dispute the payment with the credit/debit card company/bank, provided that the transactions correspond to the terms indicated in this authorization form.

_____	_____	_____
Date	**Patient name** (please print)	**Patient Signature**

If the patient is less than 18 years old:

I am the parent or legal guardian of the patient named above. I agree that I am responsible for all bills resulting from the Practice's services for the patient, that I will pay all such bills in a timely fashion, and that all payment terms set forth above, in the Consent to Treatment, and in any other document governing the patient's services and payments shall apply to me.

_____	_____
Signature of Parent/Legal Guardian	**Name of Parent/Legal Guardian** (please print)

_____

Relationship to Parent

Mindwaves

Consent for Payments via Credit/Debit Card

Name on Card (as it appears on the card): _____
First MI Last

Type of Card: □ *VISA* □*MasterCard* □*Other*_____

Card Number: __ __ __ __ ----__ __ __ __ ---- __ __ __ __----__ __ __ __

Expiration Date: (mm) _____ / (yr) _____ **Security Code:** _____

Card Billing Address: _____
Street Apartment City ZIP

I, the signatory below, am the person responsible for paying the bills of the client named below. I agree to allow Mindwaves Mental Health, LLC ("MMH"), to securely store my credit/debit card (the "card") listed above. By signing this form, I authorize MMH to use the card automatically to pay for services rendered, missed or forgotten payments, no-shows/cancellations within 24 hours, and any other patient payments (collectively, the "Fees"). If I want to designate a different payment method or if there is a change in my payment method information, I must inform MMH in writing of these changes at least fifteen (15) days prior to the scheduled payment date.

I represent and warrant that (i) the card information I supply is true, correct, and complete, (ii) charges to my card will be honored by my card company/bank, (iii) I will pay the charges incurred in the amounts posted, including any applicable taxes, and (iv) I am the person in whose name the card was issued and I am authorized to make purchases and other transactions with the card.

I authorize MMH to use my card to bill automatically all Fees incurred pursuant to the Consent to Treatment, or such other fee schedule that we agree on from time to time.

If MMH is unable to secure funds from my card for any reason, including, but not limited to, insufficient funds in the card or insufficient or inaccurate information that I provided when submitting electronic payment, MMH may undertake further collection action, including application of fees to the extent permitted by law.

I have the right to revoke this authorization by notifying MMH at least fifteen (15) days prior to the scheduled payment date. I understand and acknowledge that services may be cancelled or withheld if I revoke this authorization, and that I am still responsible (and my card may be charged) for all fees incurred by me or otherwise owed to MMH. This authorization will remain in full force and effect until revoked by me or MMH.

I acknowledge and agree that I will not dispute the payment with the credit/debit card company/bank, provided that the transactions correspond to the terms indicated in this authorization form.

_____	_____	_____
Date	**Patient name** (please print)	**Patient Signature** *(if at least 18 years old)*

If the patient is less than 18 years old, and is not an emancipated minor):

_____	_____	_____	_____
Signature of Parent/Legal Guardian	**Name of Parent/Legal Guardian**	**Relationship to Patient**	**Date**

Mindwaves

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Mindwaves Mental Health (the "Practice") provides a broad range of psychiatric and mental health services.

When you receive care from the Practice, we will create a patient record, which can be paper, electronic, or both. The patient record has information about your medical and/or mental health history and status, your treatments, and your progress. It may also contain sensitive information such as treatment for substance abuse or HIV.

Who Will Follow This Notice

● The Practice and your individual clinician(s)
● All other members of the Practice's workforce.

Summary of Your Rights

You have the right to:
• Get a copy of your paper or electronic patient record
• Correct your paper or electronic patient record
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we've shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe that your privacy rights have been violated

Summary of Your Choices

You have some choices in the way that we use and share information as we:
• Tell family and friends about your condition
• Provide disaster relief
• Provide medical and mental health care

Which Information do we collect?

Through your use of the Messaging Service, we will receive Personal Information through our third-party service provider. "Personal Information" is information that individually identifies you, such as your mobile phone number you provided when signing up for the Messaging Service, any user or screen name that you select in connection with the Messaging Service, any comments or feedback regarding the Messaging Service that you send to us, or any other information that you choose to include in messages you send through the Messaging Service. When you send messages via the Messaging Service, we will also collect your messaging history and any information included in those messages.

We may also collect Personal Information about you using cookies or similar technologies. Cookies are pieces of information that are stored by your browser on the hard drive or memory of your device. Cookies enable personalization of your experience on the Messaging Service (e.g., sending you personalized text messages such as reminders).
We will also collect your contact information if you contact us with questions about the Messaging Service or for any questions regarding our practice.

How do we process your Information
We use Personal Information to deliver, analyze, maintain and support the Messaging Service. We may also use Personal Information to enhance the Messaging Service features and customize and personalize your experiences on the Messaging Service.

When and with whom do we share your Information
SMS opt-in information and phone numbers collected specifically for SMS purposes are NOT shared with third parties.

SMS For Consent Communication
The information obtained as part of the SMS consent process will not be shared with third parties for marketing purposes.

Types of SMS Communications
If you have consented to receive text messages from Mindwaves Mental Health, you may receive text messages related to appointment reminders, follow-up on cases.

Message Frequency
Our SMS message frequency will be from 50 to 250 text messages daily across all users.

Potential Fees for SMS Messaging:
Many carriers charge a fee for each message sent or received. This can vary depending on the carrier's pricing structure and whether the message is sent domestically or internationally.

Protection of Information
Mindwaves Mental Health takes a variety of physical, technical, administrative, and organizational security measures based on the sensitivity of the information we collect to protect your Personal Information against accidental or unlawful destruction or accidental loss, alteration, unauthorized disclosure or access. Unfortunately, no online activity can be guaranteed to be 100% secure. You should note that in using the Messaging Service, your information will travel through third-party infrastructures which are not under our control (such as a third-party provider's SMS delivery platform or your carrier network). While we strive to protect your information against unauthorized use or disclosure, we cannot ensure or warrant the security of any information you provide. By using the Messaging Service, you agree that Mindwaves Mental Health is not liable for any unintentional disclosure.

Please note that the Practice does not use or share your information for inclusion in hospital directories, to market services, to sell your information, or to raise funds. If we ever change our policy against such uses and disclosures, we will not do so without informing you by means of a revised Notice of Privacy Practices, and (to the extent required by law) seeking your consent.

SMS
The SMS opt in or phone numbers for the purpose of SMS are not being shared with third parties for marketing purposes. SMS Text messaging originator opt-in data and consent will not be shared with any third parties.

Summary of Our Uses and Disclosures
We may use and share your information as we:
• Treat you
• Run our organization
• Bill for your services
• Help with public health and safety issues
• Do research
• Comply with the law
• Work with a medical examiner or funeral director
• Address workers' compensation, law enforcement, and other government requests
• Respond to lawsuits and legal action

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibility to help you.

Get an electronic or paper copy of your medical record
• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
• We may say "no" to your request, but we'll tell you why in writing within ti0 days.

Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information

• You can ask for a report of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us by email at contact@mymindwaves.com or by phone at 470-826-2233
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letterer to 200 Independence Avenue, S.W., Washington, D.C. 20201, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care

• Share information in a disaster relief situation
• Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your informa9on if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We have no plans to share your information for the following purposes, but be assured that we will never do so without your written permission:

• Marketing purposes
• Sale of your information

The Practice does not engage in fundraising. If this changes, we may contact you for fundraising efforts, but you can tell us not to contact you again about that.

Our Uses and Disclosures

How do we typically use or share your health information

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you may ask your primary care physician about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use health information to monitor the quality of our care to and to make improvements.

Example: We may use health informa9on about you to monitor the success of your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from you or other entities.
Example: If we begin accepting insurance reimbursements, we may give information about you to the insurance company.

How else can we use or share your health information
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- *Preventing disease*
- *Helping with product recalls*
- *Reporting adverse reactions to medications*
- *Reporting suspected abuse, neglect, or domestic violence*
- *Preventing or reducing a serious threat to anyone's health or safety*

Do research
Under certain conditions, we can use or share your information for health research. (At the present time, the Practice only uses "de-identified" information for research – information that does not reveal your identity, and cannot ever be reconnected to you.)

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral

director when a patient dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

• *For workers' compensation claims*

For law enforcement purposes or with a law enforcement official

• With health oversight agencies for activities authorized by law

• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.

• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

• We must follow the duties and privacy practices described in this notice and give you a copy of it.

• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/nottcepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

• This notice is effective as of September, 2024

• The Practice's Privacy Officer is Sachin Soni. You may contact the Privacy Officer by email at contact@mymindwaves.com or by phone at 470-826-2233.

Mindwaves

Receipt of Notice of Privacy Practices Written Acknowledgment

I am a patient of MINDWAVES MENTAL HEALTH. I acknowledge that I have received the Notice of Privacy Practices (the "Notice") from MINDWAVES MENTAL HEALTH, and that I have been provided an opportunity to review it.

I understand that:

- I have certain rights to privacy regarding my protected health information.
- MINDWAVES MENTAL HEALTH can and will use my health information for purposes of my treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how MINDWAVES MENTAL HEALTH may use and share my protected health information for other purposes.
- I have the rights regarding my protected health information listed in the Notice.
- MINDWAVES MENTAL HEALTH has the right to change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

_____ _____

Signature of Patient Date

If the Patient is an unemancipated minor or otherwise incapacitated (physically or mentally):

_____ _____

Signature of Guardian/Personal Representative Date

_____

Description of Authority or Relationship

Mindwaves

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgment Form

Name of Patient:
Date of Birth:

I am a MINDWAVES MENTAL HEALTH employee or staff-member. I attempted to obtain the patient's (or the patient's representative's) signature on the Receipt of Notice of Privacy Practices Wri1en Acknowledgment form, but was unable to do so as documented below:

Reason:_____

Name: _____ Date: _____

Signature: _____

P: 470-826-2233 | F: 470-826-2233 | E: contact@mymindwaves.com
855 Peachtree St NE, Suite 3401, Atlanta, GA 30308 | mymindwaves.com

Mindwaves

TCPA Consent

You hereby expressly consent to be contacted by Mindwaves Mental Health ("The Practice") for any and all purposes relating to your appointment(s) and treatment with the Practice, including without limitations reminders of your appointment(s) and prescription renewals. As part of this consent, you consent to be contacted by the Practice at any telephone number, or physical or electronic address that you provide.

You agree that the Practice may contact you in any way, including without limitation: text messages, calls using prerecorded messages or artificial voice, and calls and messages delivered using auto telephone dialing system or an automatic texting system. Automated messages may be played when the telephone is answered whether by you or someone else. In the event that an agent or representative calls, you agree that he or she may leave a message on your answering machine or voice mail, or send one via text message. You acknowledge and accept that your cellular or mobile telephone provider will charge you according to the type of plan you carry, and that the Practice shall not be responsible for such charges.

You also agree that The Practice may contact you by email, using any email address you have provided to us or that you provide to us in the future.

You represent, warrant, and covenant (that is, you promise) that:

i. The contact information that you have provided to the Practice (such as telephone numbers, street addresses, and email addresses) is your contact information and not someone else's.

ii. You are permitted to receive calls and texts at each of the telephone numbers you have provided to us, and you are permitted to receive emails at each of the email addresses you have provided to the Practice; and

iii. You will promptly alert the Practice whenever you stop using or change your telephone number, street address, or email address.

_____
Date

_____
Signature of patient (or if patient is under 18 years old, parent/guardian)

_____
If signature of parent/guardian, please describe the relationship to patient