Myrtle Beach
630 Chestnut Rd.
Myrtle Beach, SC 29572

Loris
3997 Meeting St.
Loris, SC 29569

Florence
2141 Hoffmeyer Rd.
Florence, SC 29501

Office Phone: 843.945.1452
Fax: 843.945.1489

Email: info@apmhofsc.com
Website: apmhofsc.com

Georgetown
1837 N Fraser St.
Georgetown, SC 29440

Socastee
4325 Dick Pond Rd.
Myrtle Beach, SC 29588

Little River
4360 Big Red Barn Dr.
Little River, SC 29566

PRACTICE POLICIES & INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Clinicians may choose to use AI for documentation purposes.

CONTROLLED MEDICATION POLICY: You **MUST BE SEEN** in the office every three months or sooner depending on provider discretion for your evaluation and management of your medication. Failure to keep these appointments could prevent your medication refill. If you miss your appointment, **YOUR MEDICATION WILL NOT BE REFILLED UNTIL YOU ARE SEEN. ANY and ALL medication requests will be filled in 24-72 hours.**

TELEHEALTH APPOINTMENTS: All patients must have a completed Payment Authorization Form and have a valid card on file in order to schedule and attend telehealth appointments. The form is located on the patient portal if you need to update one. You will get a link at your time of appointment via text/email. Payment is due by 10am of appointment day.

Billing Practices and Financial Agreement: Your insurance company will require that your provider include on any billing statement of services a Procedural Code(s) called a CPT code and a Primary Diagnostic Code, or ICD Code. By submitting your insurance information and requesting that we bill your insurance company on your behalf, you are giving this practice the permission to release private information necessary to process the insurance claim on your behalf. This includes your portion of the fee not covered by your policy, including any co-payments or co-insurance, and if applicable, meeting your required annual deductible. You will also be responsible for any portion of the balance due that is denied by the insurance company, regardless of the circumstances. **In order to attend your appointment, all of copay must be paid in full. If there is a balance, at least 30% of the balance must be paid.**

Acceptable forms of payment are cash, check, or debit/credit card and flexible spending cards. If your check is deposited and returned for insufficient funds, you will be charged a $35.00 Insufficient Funds Fee. We reserve the right to temporarily suspend scheduling further appointments if an outstanding balance is not paid and/or payment arrangements are not made in advance.

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NO SHOWS & LATE ARRIVAL/CANCELATONS: Since your appointments involve the reservation of time specifically for you, a minimum of 24-hour notice is required for rescheduling or cancelling an appointment. **If 24-hour notice is not provided, you may be charged a $25.00 late cancellation appointment fee.** Appointments missed without notice is considered a **No Show which is a $50.00 fee.** Please note, insurance companies will not reimburse for missed sessions or sessions that are cancelled late, and you will be responsible for the $50.00 no-show fee or $25.00 late cancellation appointment fee to be paid prior to being seen at your next scheduled appointment time. **Confirming appointments through our email and text reminders that are sent out in advance is required for telehealth and in office appointments.**

TREATMENT TERMINATION: If you are a no-show patient with two consecutive missed appointments, or three no shows total, we will not schedule any further appointments and you will be **discharged** from the practice. If, after the intake, your nurse practitioner or therapist identifies your treatment needs are out of their scope of practice, we will refer you to an appropriate provider.

Contact of Staff Policy:
Kindly refrain from reaching out to our clinicians via Facebook. We value your privacy and want to maintain the highest standards of confidentiality. Preferred mode of communication: For any inquiries or appointment scheduling, please call our dedicated line at 843-945-1452. Our friendly staff will be happy to assist you during regular business hours. If you are experiencing medication complications or a mental health crisis, please go to your nearest emergency or call 988 Crisis hotline.

URINE DRUG SCREEN POLICY:

Initial medication management appointments require a urine drug screen for all ages 12+. This will be billed to insurance or self-pay rate of $25.00. Therapy appointments that require urine screens are self-pay only and cannot be billed to insurance.

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Advanced Practice
— MENTAL HEALTH AND WELLNESS —

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NOTICE OF PRIVACY PRACTICES

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

PHI identifies you and health care provided to you or payment for your health care, or information about your past, present, or future medical condition. This Notice explains our legal duties and privacy practices concerning your PHI. We must follow the terms of this Notice and use/disclose PHI only as described in this Notice. We may change the terms of this Notice and make the new Notice effective for all DMH PHI. You may get a copy by contacting the office where you were or are receiving services.

Unless permitted in this Notice, we cannot use/share your PHI unless you sign an Authorization. You may cancel an Authorization in writing and we will no longer use/share PHI for that purpose. However, we cannot take back any use/release made with your Authorization and we must keep records of your Treatment. Uses/Disclosures of Your PHI for Which You May Request a Restriction (see "Privacy Rights" below)

Treatment: We may use/share your PHI needed for your DMH and other providers' Treatment or care (your diagnosis, medications, treatment plan, etc.), including PHI needed for case management, consultation and referral with/to other Treatment or care providers.

Payment: We may use/share PHI (Treatment dates or types) to bill/be paid for Treatment (insurance/Medicaid/Medicare or other payer). We may also share PHI with payers before we provide Treatment to get their approval, or find out if the type of Treatment is covered.

Operations: We may use/share PHI for our Operations, for example, sharing PHI between our offices to determine what services you need. We may sometimes share PHI for Operations of agencies and organizations with health care accrediting or licensing authority.

General Notification: We may share with your caregiver, family, close friend, or a person whom you identify: your name, location where you are receiving Treatment and your general condition.

Persons Involved in Treatment/Payment: We may share PHI with your caregiver, family, close friend, or other person involved in your Treatment or Payment as needed for your Treatment or Payment.

Keep You Informed: We may phone and/or mail you reminders for appointments, need for our services, Treatment information, health care benefits or related services and satisfaction surveys.

Uses/Disclosures of Your PHI Without a Right to Request a Restriction:

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- Public Health and Health Oversight
- Court Ordered Treatment/Evaluation or Emergency Admission
- By Law

Privacy Rights Right to a Paper Copy of this Notice:

You have the right to request a paper copy of this Notice at any time by contacting the Privacy Officer.

Right to Request Restrictions: You have the right to request in writing restrictions on our use/sharing of your PHI for Treatment, Payment or Operations. You may request that PHI not be shared with others (such as your spouse). Although we are not required to agree to a request, we will accommodate reasonable requests if practical and if it will not compromise Treatment.

Right to Request Confidential Communications/Notification: You have the right to request in writing how you want us to communicate with you by indicating how/where you are to be contacted, e.g., only at work or by regular mail. We will accommodate reasonable requests if practical and if it will not compromise your Treatment.

Right to Inspect and Copy: You have the right to ask in writing to see and receive a copy (including an electronic copy if the PHI is maintained in electronic form) with applicable charges apply for copying, retrieval, postage, etc. of your PHI in a Designated Record Set. We will usually provide copies within 30 days of request. If you agree, instead of providing copies, we may provide a written summary of PHI requested (charging you the agreed upon preparation cost). If we deny a request, we will do so in writing giving our reasons and you may have the right to have that decision reviewed.

Right to Request Amendment: If you believe your PHI is incorrect or incomplete, you may ask in writing that we amend it, stating why the PHI is inaccurate or incomplete. Normally we will respond in writing within 60 days of your request. We may deny your request if the PHI was not created by DMH, is not part of the Designated Record Set you may see and copy, or if it is accurate and complete. If so, we will let you know in writing giving our reasons. You may file a written disagreement and we may provide you with a written reply.

Right to an Accounting of Disclosures: Accounting does not include disclosures made: for Treatment, Payment or Operations; for general notification; to you or your caregiver; made by Authorization; for national security or intelligence; to correctional facilities/law enforcement holding custody; or to health oversight/law enforcement if it would impede those activities. We will normally provide an accounting within 60 days of request. The first list within a 12 month period will be free. We will charge you for any subsequent list within the 12 month period.

Right to File a Complaint: You have the right to file a written complaint with the Privacy Officer and/or HHS as described on the first page.

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Consent for Treatment, Notice of Privacy, & Policies Acknowledgement

I have read The Informed Consent for Assessment and Treatment and Office Policies and Notice of Privacy Practices and I understand and accept the policies contained therein. Having read that information, I hereby agree to assessment and treatment. I acknowledge that this consent is truly voluntary and is valid until revoked. I hereby consent for my provider to release information to the billing agent/funding source and for the billing agent/funding source to release information to your provider. I understand that I am responsible for any fee not covered by insurance and agree to pay for sessions or co-pays at time of service. I authorize the release of any information relating to all claims and benefits submitted on my behalf or on behalf of my child or minor in my legal custody. I further acknowledge that my signature here authorizes the clinician or his/her billing specialist to submit claims for services rendered without obtaining my signature on every claim. I understand that I am responsible for paying the co- pay, coinsurance or deductible amount at the time of service. If the claim is denied, I agree to pay for the service. I authorize payment of medical benefits for assessment or psychotherapy to the providing clinician, for services rendered. I acknowledge that I have reviewed and understood the Consent for Treatment and Practice Policies. I voluntarily consent to evaluation and treatment, including telehealth services when applicable, and understand that results are not guaranteed and that I may withdraw consent at any time. I acknowledge receipt of the Notice of Privacy Practices and understand how my health information may be used and disclosed.

________________________ ________________________

Patient Name

Patient Signature
(If signed by other than Patient, indicate relationship)

________________________ ________________________

Date of Birth

Todays Date