**Consent To Treatment**

At your initial evaluation, you consent to receive a comprehensive diagnostic assessment. All communication and clinical treatment will be documented in the patient chart. Both the law and the standards of the profession require such. You are entitled to receive a copy of these records, unless (as in rare circumstances) we believe that seeing these records would be emotionally damaging. The fee for
records is $25.00 unless we are providing your records to another provider. If this is the case, we will be happy to provide the records to an appropriate mental health professional of your choice, or to prepare an appropriate summary instead.

**Confidentiality**

While we believe that communication with other members of your treatment team as well as with family, where appropriate, helps to deliver the best clinical care, *Pathways To Wellness* will not release information without your written permission. However, there is no guarantee of confidentiality under the following conditions:

* If we suspect you are in imminent danger or harm to yourself or another person, or if we suspect a child or elderly person is being abused or neglected.
* If a court orders a release of information.
* If you initiate a malpractice lawsuit, or a billing dispute with a financial institution.
* If your insurance company requests to review your case.
* If you pay by credit card, our name will appear on your credit card statement (*Pathways To Wellness*).
* If you do not pay your bill, your balance due statement (including diagnostic and procedural codes) may be sent to a collection's agency or other responsible party.

**Appointments**

Dr. Hudson offers both in person and telehealth appointments. A secure teleconferencing software is used to conduct video appointments. You will be provide with instructions on how to access this application should you choose to use it. For an optimal visit, you should be connected to a secure internet connection and in a private area for the duration of your visit. At times, technology can fail. Dr. Hudson may be willing to conduct the visit through a different platform such as FaceTime or Zoom. Please note, these platforms are not secure and while the likelihood of transmission being intercepted for viewed is small, we cannot be responsible for the security of these visits. Alternately, if technology fails due to unforeseen circumstances, a visit may be conducted via telephone.

**Cancel/Missed Appointments**

A twenty-four-hour notice is required for canceled appointments. **YOU WILL BE CHARGED $75.00 FOR MISSED APPOINTMENTS/ LATE CANCELLATIONS**. You may leave a message after hours for canceled appointments. Your insurance will not reimburse you for missed appointment charges should you choose to file this claim.

**Communication outside of scheduled appointments**

You may message Dr. Hudson through a secure patient portal within the electronic medical record; this operates like email and is accessed by Dr. Hudson only. You may also call or text the main telephone number with questions or refill requests. Messages are addressed routinely throughout the day. Unless you have an emergency, all messages will be returned as soon as possible. If you have a true emergency after office hours call 911 or go to your local emergency room. Routine refill requests will not be addressed after hours. Please note that it may take up to two business days to fulfill requests for prescription refills.

**Agreement**

By signing below, I acknowledge that I have read, understood and agreed to all of the policies on this page. I agree to an evaluation and/or treatment at *Pathways To Wellness*, and I authorize *Pathways To Wellness* to furnish information to my insurance carriers concerning my treatment**.** I assign to *Pathways To Wellness* all payments for services provided to me. I understand that it is my responsibility to obtain in advance a referral to *Pathways To Wellness* from my primary care doctor, employee assistance program or other gatekeeper, if required by my insurance company. I agree to be responsible for all charges incurred because of my evaluation and/or treatment at *Pathways To Wellness* regardless of insurance coverage or pending litigation. I further understand that charges are subject to being turned over to a credit bureau and/or collection agency if not paid within 120 days. I also understand that I will be charged for cancellations made with less than 24-hour notice or in the event I fail to keep my scheduled appointment. I give my permission to *Pathways To Wellness* to contact me, when necessary, at any of the telephone numbers I have provided.

Your agreement to these terms and conditions is required for you to receive professional services from *Pathways To Wellness*. If you do not agree, we will be glad to provide you with names of other providers. Your signature below confirms that you have read and understood all of the policies above and you agree to these terms and conditions.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_