Sekou Jones, MSN, PMHNP - Calm Clarity Mental Health
7955 E Arapahoe Ct #3400, Centennial, CO 80112-6829
(303) 898-2267 phone (720) 287-3666 fax office@calmclaritymh.com

Office Policies

PAYMENT: Full payment for services is due at the time of service. Accepted methods include: HSA or FSA cards, credit / debit cards, cash or checks. A $25 fee shall apply to all returned checks. Any client with a balance 30^{+} days past due is subject to late fees and suspension of treatment until the bill is paid.

INSURANCE: Calm Clarity Mental Health (CCMH), the office of Sekou Jones, is not currently "in-network" with any commercial health insurance companies. Clients are solely responsible for communicating with their insurance companies regarding any applicable out-of-network benefits, policy restrictions or reimbursement protocols. Regardless of insurance coverage, clients must pay all fees at the time of visit. Any eligible reimbursement would then be paid directly from the insurance company to the client. CCMH can supply any necessary documentation to assist the client's submission for reimbursement.

FEES:

- Initial evaluation- **$285** (90 min.)
- Psychotherapy- **$145** (55 min.);
- Medication & counseling: **$175** (55 min.)

REPORTS, CONSULTATIONS, OTHER CLERICAL MATTERS: A fee of $**150/hr**. shall be billed for clinician time beyond scheduled appointments for official reports, forms, professional consultations, or other client requests. Clients will be advised beforehand if such fees may apply.

PHONE CALLS: There is no fee for calls under 15 minutes, calls to schedule appointments, calls regarding recently prescribed medications and/or when calling at the instruction of the clinician (S. Jones, NP). All other calls greater than 15 min. will be billed at a rate of **$150/hr**.

CANCELLATION POLICY: In the interest of honoring each client's time and all our clients' needs, we ask that you please contact our office **at least 24 hours ahead of time on the prior business day** if you need to cancel or reschedule your appointment. Clients will be billed the full visit fee in the event of missed appointments or late cancellations.

PATIENT RIGHTS: You are entitled to be highest quality of psychiatric care available. Psychotherapy is a joint undertaking, with rights and responsibilities shared by both the patient and the provider. I am always interested in responding to whatever questions, concerns, or feelings you may have regarding your care.

Over time, these office policies may be adjusted. Clients will be informed of any changes and may obtain an updated copy of office policies at any time.

Release and Statement of Responsibility

1) I have read and understand the above information.
2) I agree to be terms of the office payment and cancellation policies.

SIGNATURE: _____ DATE: _____

NAME: _____

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Notice of Privacy Practices / HIPAA Compliance

PURPOSE:
Calm Clarity Mental Health (CCMH), the office of Sekou Jones, NP, is required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA). CCMH will abide by the terms of the notice currently in effect. The client or responsible party may obtain a copy of this notice upon request. If there is a change in the Notice of Privacy Practices, an updated notice will be provided at that time.

USES AND DISCLOSURES:
The client's Protected Health Information (PHI) may be used by this office for the purposes of treatment, payment and health care operations.

- For *treatment*: Sekou Jones, NP may review, modify, and summarize your health information to develop and carry out a treatment plan. From time to time, Mr. Jones may consult a colleague for the purposes of providing the best care without referencing the client's full name or personally identifying information. Protected Health Information (PHI) will not be disclosed to any other individuals or organizations without obtaining a release of information from the client, guardian, or legally authorized individual.
- For *payment*: Sekou Jones, NP or CCMH personnel may disclose the following PHI to a health insurer or other payor source when necessary (including, but not limited to): treatment summaries, diagnoses, medications, primary symptoms and clinical status.
- For *healthcare operations*: Sekou Jones, NP or CCMH personnel may need to speak with a pharmacist, first responder or other healthcare provider regarding your care.

Consent to Treatment

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services by Sekou Jones, MSN, PMHNP-BC of Calm Clarity Corp., operating as Calm Clarity Mental Health. Services provided by this independent professional practice may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other related clinical interventions.

I, the undersigned, acknowledge that:

- I have read and understand the above information.
- I have the right to be informed of and participate in the plan of care.
- I agree to the notice of privacy practices.
- I have the right to specify any limitations or exclusions to the disclosure of my health information.
- I have the right to receive a copy of this consent.
- I have the right to withdraw this consent at any time.

Client's Name (please print)	Client's Signature (or responsible party)	Date

If signed by Responsible Party, please state relationship to client:

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Patient Rights & Responsibilities

You have the RIGHT:

- To be treated with respect, consideration, and dignity.
- To receive excellent healthcare, consistent with established standards of clinical practice.
- To the privacy and confidentiality of your health information and health records.
- To receive a Notice of Privacy Practices & HIPAA Compliance indicating how Protected Health Information (PHI) will be disclosed.
- To request restrictions to the use and disclosure of Protected Health Information (PHI).
- To be an informed participant in treatment decisions and to be advised of the anticipated benefits, side effects and common complications of treatment.
- To ask questions at any time and receive available information concerning evaluation, diagnosis, treatment and prognosis.
- To consent to or refuse any care or treatment.
- To receive appropriate referrals to other providers and services.
- To file a complaint against the provider or staff without fear of reprisal.

You have the RESPONSIBILITY:

- To give accurate information about your substance use, health history, known allergies or sensitivities, all medications & supplements.
- To ask questions or clarification about anything you do not understand.
- To report any significant changes in symptoms or failure to improve.
- To keep appointments or cancel in a timely manner. *(See CCMH cancellation policy)*
- To learn the names, purpose, and effects of medications prescribed to you.
- To partner with the clinician to develop your plan of care and adhere to the plan as best you are able.
- To notify the clinician if you are no longer following the plan of care, for whatever reason.

Client's Name (please print)	Client's Signature (or responsible party)	Date

If signed by Responsible Party, please state relationship to client: