

The Stable Mind, PLLC
Dallas Acker, PMHNP-BC

814-261-2758



TELEPSYCHIATRY CANCELLATION POLICY

Effective Date 7 / 31 / 25

Thank you for choosing THE STABLE MIND, PLLC for your psychiatric care. This policy applies to all telepsychiatry (or telehealth) appointments at our practice. This policy is designed to ensure the effective use of resources and to accommodate other patients who may need to schedule telepsychiatry appointments.

By booking a telepsychiatry appointment with us, you acknowledge that you have read and understand this Cancellation Policy and agree to be bound the terms and conditions below.

[Cancellation/Rescheduling Policy](#)

We understand that situations arise that require you to change your plans. In such event, we ask that you please give us a minimum of 24 hours' advance notice when cancelling or rescheduling your telepsychiatry appointment. This allows us to offer the appointment slot to other patients and manage scheduling efficiently.

In order to cancel or reschedule your appointment, you should contact us via phone at 814-261-2758 or email at dallas@thestablemind@gmail.com. Please provide your full name, appointment date, and reason for cancellation or rescheduling request. Please note that all rescheduling requests are subject to availability and no new day or time slot can be guaranteed.

Appointments cancelled or rescheduled within 24 hours of the appointment time will be charged a fee of \$ 75. This charge is non-refundable and is not applicable toward any future services with us.

"No Shows"

A "no-show" is defined as a missed appointment without prior notice. Patients who do not attend their scheduled telepsychiatry appointment and do not provide advance notice will be charged a no-show fee of \$ 100. This charge is non-refundable and is not applicable toward any future services with us.

Exceptions

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In cases of emergency or unforeseen circumstances, patients should contact us as soon as possible. We reserve the right to waive fees at the discretion of the provider.

Late Arrivals

We understand that you have a busy schedule and can sometimes be delayed in logging on for your appointment. Please promptly notify us to let us know if you are running late.

We allow a 5 minute grace period for you to log on to your scheduled telepsychiatry appointment time. If you are more than 5 minutes late to your appointment, we may need to reschedule you. In such event, this will be treated as a cancellation and you will incur a charge of \$ 25 at the discretion of provider.

If we do not hear from you at all within 10 minutes from your appointment time, then your appointment will be considered a “no show” and will be charged a fee of \$ 100 a the discretion of provider.

Same Day Appointments

If you make a telepsychiatry appointment for the same day, then you may cancel or reschedule your appointment up to 2 hours prior to your appointment time. Any cancellations or rescheduling within 2 hours from your appointment time will be charged in accordance with the policies described above.

Contact Us

If you need to make changes to your appointment, we ask that you please contact us via any of the following methods:

Phone: 814-261-2758

Email: dallas@thetablemind@gmail.com

Text Message: 814-261-2758

Availability and After-Hours Emergencies

Providers check for voice mail messages during normal business hours. Messages left outside of normal hours of operation will be picked up the next business day. If you are experiencing suicidal or homicidal thoughts, are in crisis, or need immediate help, please call 911 for MEDICAL emergencies or go to the nearest emergency department. If the emergency is MENTAL HEALTH in nature, please call 988 for crisis.

Contacting Me

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voicemail and I will return your call once I've reviewed your chart, but it may take a day or two for non-urgent matters. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice. If I need to cancel an appointment at the last-minute, I will reach out as soon as possible and reschedule, or have a member of my staff connect with you.

Discharge Process

There are several reasons why we may eventually end our professional relationship. You may decide you would prefer to work with a different provider. I may reach the conclusion you would be better served working with someone else. Regardless of the case, I will first discuss with you the reasons for discharging, and if you request, provide you with a list of other qualified providers. I will also extend the discharge process length if necessary based on your treatment needs, including continuing to provide emergency support for a time-limited period after you have been notified of the end of our treatment relationship.

Please note that ongoing failure to pay for treatment, attend sessions, or communicate with me in a respectful and timely manner can also result in discharge from my practice. In these instances, to ensure you have continued access to care, I will still make every reasonable effort to get in touch with you and provide referrals to a new provider before I consider our relationship ended.

NOTICE OF PRIVACY PRACTICES:

The Stable Mind, PLLC

Saegertown, PA

814-261-2758

NOTICE OF PRIVACY PRACTICES

(behavioral/mental health)

Effective Date 7 / 31 / 25

This Notice of Privacy Practices (the “Notice”) describes how medical information about you, as the patient of the following behavioral/mental health practice: THE STABLE MIND, PLLC (the “Practice”), may be used and disclosed, and how you can get access to this information. This Notice is required by the privacy regulations created under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). *Please read it carefully.*

PRIMARY USES AND DISCLOSURES

This section describes the primary ways we use and/or share your health information. We may use and disclose your health information about you in the following ways:

For Your Treatment. We can use your health information and share it with other health care professionals who are treating you including, but not limited to: doctors, nurses, technicians, health students, or other personnel who are involved in your treatment and care. These other healthcare professionals may work at our Practice, at a hospital if you are hospitalized under our supervision, at another doctor’s office, lab, pharmacy, or other health care provider that we may refer you to for consultation or treatment.

For Our Practice Operations. We can use and share your health information to run our Practice, manage and improve your care, and contact you when necessary. We may use your health information to review our provision of treatments and services and to evaluate the performance of our staff. We may combine health information about many patients,

including you, to decide what additional services we should offer, what additional services may be needed, whether new services and treatments are effective, or to compare ourselves to other practices to see where we can make improvements. In some cases, we may remove information that identifies you from this set of health information so that others can use it for purposes of studying and analyzing health care metrics and information.

For Payment Purposes. We can use and share your health information so that the treatment and services you receive from us can be billed to and payment collected from you, an insurance company, health plan, or other third party. We may need to give your health plan information about your visit so they can pay or reimburse us for the visit. We may also tell your health plan or third-party payer about a treatment you are planning to receive in advance of your receiving such treatment in order to determine if your plan will cover the treatment.

OTHER PERMITTED USES AND DISCLOSURES

We are also allowed, or may be required to share your information, in other ways, which include the following:

For Public Health Purposes. We can share your health information in certain public health situations such as:

- To prevent disease
- To assist with product recalls
- To report adverse reactions to treatments or medications
- To prevent or reduce a serious threat to anyone's health or safety

As Required by Law & Legal Proceedings. We will share your health information if local, state, or federal law requires it, including, without limitation if the Department of Health and Human Services requests it to ensure we are complying with federal privacy laws. We may also disclose your health information when we are legally required to do so for any

judicial or administrative proceeding, in response to an order of a court or administrative tribunal, or in certain conditions in response to a subpoena, discovery request or other lawful purposes.

For Purposes of Health Oversight. We may disclose your health information to health oversight agencies for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information may include government agencies that oversee the health care system, government benefit programs, other government regulatory programs.

In Relation to Communicable Diseases. We may disclose your health information, if authorized by law, to a person who may have been exposed to a communicable disease or otherwise may be at risk of contracting or spreading the disease or condition.

In Cases of Abuse or Neglect. We may disclose your health information to a public health authority that is authorized by law to receive reports of child abuse, domestic violence, or neglect. In addition, we may disclose your health information if we believe that you have been a victim of abuse, domestic violence, or neglect to the governmental entity or agency authorized to receive such information.

As Required by the Food and Drug Administration. We may disclose your health information to a person or company required by the Food and Drug Administration (“FDA”) for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, without limitation, reporting of product defects or problems, adverse reactions and/or events, biologic product deviations, product tracking purposes, to aid in product recalls, to aid in making repairs or replacements, or for conducting post marketing surveillance, as such may be required.

For Research Purposes. We can use or share your information for health research purposes.

In Response to Organ and Tissue Donation Requests. We can share your health information with organ procurement organizations.

To Work with a Medical Examiner or Funeral Director. We can share your health information with a coroner, medical examiner, or funeral director in the event of your death.

To Address Workers' Compensation, Law Enforcement, and Other Government Requests. We can use or share your health information:

- For workers' compensation claims
- For law enforcement purposes or in working with a law enforcement official
- For special government functions such as military, national security, and presidential protective services
- With health oversight agencies for activities as authorized by law

In Relation to Military Personnel and Veterans. If you are a member of the armed forces or separated/discharged from military services, we may release your health information as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release your health information about foreign military personnel to the appropriate foreign military authorities.

To Prevent Harm. If we believe you are at risk of seriously harming yourself or others, we may disclose relevant information to the appropriate individuals or authorities (such as law enforcement or crisis response teams) in order to prevent harm, in accordance with applicable law.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights. You have the right to:

Get a copy of this Notice. You can ask for a paper copy of this notice at any time and one will be provided to you, even if you have agreed to receive the notice electronically.

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. To do this, you can contact our Privacy Officer as listed at the end of this Notice. We will provide a copy or a summary of your health information, usually within 30 days from the date of your request. We may charge you a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct your health information if you think it is incorrect or incomplete. You can submit this request to our Privacy Officer. We may deny your request, but we will tell you the reason for the denial by sending you a written letter within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, at a home or office phone) or to send mail to a different address. We will comply with 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 deny your request if we determine that 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 insurance company. We will comply with such a request 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 list of all the times we have shared your health information over the past six years, which will include who we shared it with and why we shared it. In response, we will include all disclosures made except for those about treatment, payment, health care operations, and disclosures requested by you. We will provide this list to you for free once per year, but any additional requests will be charged at a reasonable, cost-based fee.

Choose someone to act for you. If you have given someone medical power of attorney to act on your behalf or if someone has been appointed as your legal guardian, that person can exercise your rights and make choices about your health information. We will check the validity of such authorization or appointment and 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 file a complaint if you feel we have violated your rights regarding your health information by contacting our Privacy Officer. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>

We will not retaliate against you for filing a complaint.

YOUR CHOICES

With respect to some of your 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, please contact the Privacy Officer. You can tell us what you want us to do, and we will follow your instructions.

You have 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 the event you are not able to tell us your preference (for example, you are unconscious or incapacitated), we may share your health information if we believe it is in your best interest. We may also share your health information when needed to lessen a serious and imminent threat to health or safety.

- We will never share your information unless you give us your prior written consent in the following cases: Marketing purposes; Sale of your health information; Most sharing of psychotherapy notes
- With respect to fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

**About Psychotherapy Notes --* Psychotherapy notes are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a private counseling session. These notes are kept separate from your medical record and receive special protection under HIPAA. We will not share these notes without your written authorization except in limited circumstances as permitted by law.

OUR RESPONSIBILITIES

This section describes our responsibilities with respect to your health information.

- We are required by law to maintain the privacy and security of your protected health information.
- We will not use or share your health information other than as described in this Notice, unless you authorize us to do so in writing. If you authorize disclosures of your health information outside of those described in this Notice, then you may change your mind at any time by informing us in writing by contacting the Privacy Officer.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice.
- We must give you a copy 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 website (as applicable).

Telehealth and Electronic Communication. If you receive services via telehealth, we take additional steps to protect your privacy. These platforms are HIPAA-compliant, and

communications are encrypted. Please let us know if you have concerns about confidentiality during remote sessions.

PRIVACY OFFICER

If you have questions, concerns, complaints, or other requests, you should contact our Privacy Officer as follows:

Name: Dallas Acker

Address: Saegertown PA

Email: dallas@thestablemind@gmail.com

Phone: 814-261-2758

HIPAA ACKNOWLEDGMENT

The Stable Mind, PLLC

Saegertown, PA

814-261-2758

PATIENT HIPAA

ACKNOWLEDGMENT & AUTHORIZATION

(for behavioral/mental health)

Effective Date 7/31/25

This form outlines important information regarding how our behavioral & mental health practice (the "Practice") may communicate with you, manage your healthcare, and

coordinate care during and after your stay. By signing this form, you acknowledge that you have reviewed and understand your rights under the Health Insurance Portability and Accountability Act (HIPAA) and that you authorize us to communicate with you via email, phone, and text message. Please carefully review each section of the form, as your signature and initials will serve as your consent to the communication practices described. If at any time you wish to revoke this authorization, you may do so by providing written notice to our office. If you need this form in another language or accessible format, please let us know.

Notice of Privacy Practices---By signing the E-version of this you are consenting to saying you agree with the sections below that require initials/signature

_____ (*Patient/Representative Initials*) I acknowledge that I have received and reviewed a copy of the Practice's *Notice of Privacy Practices* explaining how the Practice will use and disclose my protected health information ("PHI") for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the privacy officer designated on such notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Practice and/or the Practice's business associates. I understand that the Practice's *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of the current or any revised *Notice of Privacy Practices* upon request. To the extent permitted by applicable law, I consent to the use and disclosure of my information for the purposes described in the *Notice of Privacy Practices*.

Authorization to Use PHI

_____ (*Patient/Representative Initials*) I authorize the Practice and its agents to use and disclose my PHI among the Practice, its employee and agents, and/or myself for the purposes contained in the *Notice of Privacy Practices* and for my care and treatment, including:

- Coordination of my behavioral and mental health treatment among healthcare providers within the Practice;
- Any third-party payer covering my medical services;

- Other health care professionals and institutions in the delivery of health care to me;
- Transfers to or consultations with external healthcare providers for ongoing care;
- In response to a legally sufficient subpoena or court order;
- Employees and agents of the Practice, to the degree necessary to facilitate the provision of health care services and payment for such services; and
- Otherwise as may be required by applicable law.

_____ (*Patient/Representative Initials*) *Psychotherapy Notes*: I understand that my authorization does not permit the disclosure of psychotherapy notes unless I provide a separate, specific written authorization, except as permitted by law (e.g., threat of harm, court order, etc.).

_____ (*Patient/Representative Initials*) *Substance Use Disorder Records*: I understand that if I have received treatment for a substance use disorder, those records are protected under federal law (42 CFR Part 2) and require separate, specific authorization for disclosure, unless otherwise permitted by applicable law.

Consent to Email, Cell Phone, or Text Message Usage for Appointment Reminders and Other Healthcare Communications

_____ (*Patient/Representative Initials*) I consent to the use of email, phone, and text messages as a means of communication with the Practice. I understand that these forms of communication may not be secure, and there is a potential risk that the confidentiality of my health information may be compromised. Despite these risks, I consent to the use of these methods for scheduling my appointments, reminders, and other administrative purposes. I understand that I may withdraw this consent at any time by providing written notice to the Practice.

I also consent to receiving by telephone call, text message, or voicemail transmission, communications by or on behalf of the Practice at the email, telephone number, or text

address I have provided, or any other contact information in my patient record. I consent to receiving such communications to any email, text address, or telephone number forwarded to or transferred from that address or number. Healthcare communications include, but are not limited to, treatment-related messages, reminders, insurance or billing inquiries, and requests for feedback through surveys or public reviews. I authorize that these communications may be made using an automated system for dialing numbers or playing prerecorded messages and may be initiated by the Practice or someone acting on its behalf.

Disclosures to Friends, Family, or Other Designated Representatives

If you would like to designate a friend, family member, or other individual with whom the provider may discuss your medical condition, then please such list below.

_____ (*Patient/Representative Initials*) I give permission for my PHI to be disclosed for purposes of communicating results, findings, other health care decisions, and for the Practice to discuss my health status with the following individuals:

<u>Name</u>	<u>Relationship</u>	<u>Contact Number</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Can we leave a message at the above phone numbers? Yes / No

Emergency Communications

_____ (*Patient/Representative Initials*) I understand that in the event of a mental health crisis or emergency, that the Practice may need to contact my designated representative(s) urgently. By initialing, I authorize the Practice to use the contact information I have provided herein (email, phone, text message) to communicate with me or my designated representative(s) regarding my mental health status, treatment, or urgent care needs during a crisis. I understand that, while the Practice will make every effort to protect my privacy, emergency communication may include sensitive mental health information and may occur through less secure methods (e.g., phone, voicemail, or text message) if necessary to ensure timely intervention.

Additional Acknowledgments

_____ (*Patient/Representative Initials*) I understand that I may revoke or modify the authorizations contained herein in writing by contacting the Practice or the privacy officer as stated in the *Notice of Privacy Practices*, except to the extent that information has already been disclosed based on this authorization.

_____ (*Patient/Representative Initials*) I understand that the term “protected health information” or “PHI” is individually identifiable information about me, as the patient, and that it includes my past, present, or future healthcare and is transmitted and/or stored by a covered entity or business associate.

_____ (*Patient/Representative Initials*) I have had the opportunity to place special restrictions upon the authorizations herein. Any special restrictions are listed as follows:

_____ (*Patient/Representative Initials*) I understand that this executed authorization will be stored in my medical record and will be available to me upon request. A copy of this authorization is considered as valid as the original. This authorization does not have an expiration date and will remain in effect until updated or revoked in writing.

I certify that I have read and fully understand the statements above on all pages, that I have had an opportunity to ask questions about this form and all of my questions have been answered to my satisfaction, and I consent fully and voluntarily to its contents.

* If patient is unable to sign on behalf of self, then complete the following section:

Representative Signature: _____

Print name: _____

Date: _____

Relationship to Patient: _____

(e.g., parent, spouse, representative, guardian, etc.)

Reason:

Minor

Incapacitated

Other (specify): _____

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** If you are a legal representative of the patient named above, you must provide documentation proving your valid legal authority to give consent on behalf of the patient (e.g., power of attorney, healthcare surrogate form, court order, appointment of a guardianship, order appointing personal representative, letter of administration, etc.).*

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Witness --

-

Signature: Dallas Acker

Print Name: Dallas Acker

Date: _____

Address: _____

FOR OFFICE USE ONLY

We have made every effort to obtain a written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because (*choose one*): THIS WILL BE COMPLETED ON PAPER IF APPLICABLE, SIGNING THIS ELECTRONIC VERSION IMPLIES THE CLIENT AGREED WITH HIPAA ACKNOWLEDGMENT.

BEHAVIORAL HEALTH INFORMED CONSENT:

The Stable Mind, PLLC

Saegertown, PA

814-261-2758

BEHAVIORAL HEALTH

INFORMED CONSENT

This form provides an overview of behavioral and mental health services offered at our practice, outlines the potential benefits and risks, reviews your rights as a patient, and seeks your informed consent to participate in treatment. Please read carefully and ask your provider if you have any questions before signing. If you require this form in another

language or accessible format, or need accommodations for your treatment, please notify us so we can assist you appropriately.

About Behavioral Health

Behavioral health treatment involves working with a licensed mental health professional to address emotional, psychological, or behavioral challenges affecting your daily life and relationships. Treatment may include individual, couples, or group therapy, as well as evidence-based approaches like cognitive-behavioral therapy (CBT), trauma-informed care, and mindfulness techniques. Your care will be tailored to your specific needs and goals, focusing on understanding and managing your thoughts, emotions, and behaviors in a constructive way. Sessions typically last 45 to 60 minutes and may occur weekly or biweekly, either in person or via secure telehealth platforms. If you choose to participate in telehealth sessions, you will be asked to sign a separate telehealth consent form in addition to this consent form.

Therapy is a collaborative process, and your active participation is key to progress. You can expect open, respectful dialogue in a safe, supportive environment, where you may explore current concerns, personal history, and coping strategies. While therapy can lead to increased emotional awareness, stronger relationships, and symptom relief, it can also bring up difficult emotions and requires time and commitment. Your therapist will offer guidance and support, but your honesty and engagement will play a central role in achieving meaningful change. You are always encouraged to ask questions or express any concerns about your treatment.

This consent will remain in effect for the duration of your treatment unless you withdraw it in writing or until updated by the practice.

Confidentiality

Your privacy is very important to us, and the information you share during your sessions will be kept confidential. This means that what you discuss with your provider will not be shared without your permission. If you would like your provider to discuss your treatment with another person, such as a family member or another healthcare provider, you will need to sign a release form giving them permission to do so.

It is important to note that there are some exceptions to this rule where the law requires your provider to break confidentiality. These situations include:

- If you share that you are planning to harm yourself or others (such as thoughts of suicide or harming someone else).
- If your provider suspects that a child, elderly person, or vulnerable adult is being abused or neglected.
- If your records are requested by a court order or subpoena

In these rare cases, your provider must share certain information to protect your safety or the safety of others. If this happens, your provider will discuss it with you as much as possible. Additionally, some providers may be under the supervision of another mental health professional, which means your case might be reviewed by a supervisor to ensure you are receiving the best care. If this applies to your provider, they will let you know.

Risks and Benefits

Benefits of behavioral health treatment include, but may not be limited to:

- *Improved emotional regulation:* Learn techniques to better manage overwhelming feelings such as anxiety, anger, or sadness in healthy and constructive ways.

- *Enhanced self-awareness*: Gain deeper insight into your thoughts, emotions, behaviors, and patterns, which can lead to more intentional and effective decision-making.
- *Symptom reduction*: Experience relief from symptoms associated with mental health conditions such as depression, anxiety, post-traumatic stress disorder (PTSD), and others.
- *Strengthened coping skills*: Develop practical strategies for managing stress, life transitions, and interpersonal challenges.
- *Improved relationships*: Increase communication skills, boundary-setting, and empathy, which can strengthen personal and professional relationships.
- *Greater sense of control and well-being*: Feel more empowered to address challenges, make positive changes, and achieve personal goals.
- *Personal growth and resilience*: Foster a stronger sense of identity, purpose, and emotional resilience over time.
- *Safe and supportive environment*: Engage in a confidential and nonjudgmental space where you can explore sensitive or difficult topics.

Risks of behavioral health treatment include, but may not be limited to:

- *Emotional discomfort*: Discussing painful memories, emotions, or experiences may temporarily increase feelings of sadness, anxiety, anger, or distress.
- *Relationship disruption*: Changes in thoughts, behaviors, or emotional responses during therapy may lead to shifts or tensions in personal relationships.

- *Symptom fluctuation*: In some cases, symptoms may initially worsen before improvement is observed as deeper issues are addressed.
- *Unanticipated personal insights*: Gaining new awareness about oneself may lead to difficult realizations or decisions regarding one's lifestyle, values, or relationships.
- *Lack of immediate results*: Progress may take time and may not follow a linear path; some patients may experience frustration with the pace of change.
- *Dependence on therapist*: There is a potential for developing over-reliance on the therapist for decision-making or emotional support if clear boundaries are not maintained.
- *Treatment may not be effective for all individuals*: Despite best efforts, not all individuals respond to therapy in the same way, and some may require alternative or additional treatment approaches.

Results of Treatment

It is important to understand that results of behavioral health treatment can NOT be guaranteed. Each person's response to treatment is unique, and outcomes can vary based on individual factors such as the specific nature of your condition, how you respond to the therapy, your commitment to your care and treatment plan, and other personal health and lifestyle factors.

Achieving the best results often involves a process of trial and error, where adjustments to your treatment plan may be necessary to find what works best for you. Consistently following the prescribed treatment plan and attending regular follow-up appointments are crucial for monitoring your progress and making any needed changes to your plan. Your active participation and open communication with your provider are key to optimizing your treatment outcomes.

In some cases, if your condition is severe or if you experience significant difficulties despite treatment, more intensive treatment may be required. This could include a higher level of mental health or psychiatric care. Your provider will discuss these options with you if necessary.

Contraindications

Behavioral health treatment in a private practice setting may not be appropriate for all individuals. Certain clinical situations require a higher level of care and supervision than private practice or outpatient therapy can provide. For example, individuals experiencing acute psychiatric symptoms that pose an immediate risk of harm to themselves or others—such as active suicidal or homicidal ideation, or psychosis—may require inpatient hospitalization or intensive crisis intervention services. Similarly, those with severe mental health conditions that significantly impair their ability to function or engage meaningfully in treatment may benefit from more structured or comprehensive care settings.

Patients who are unable to consistently attend sessions, follow treatment recommendations, or maintain basic safety and stability outside of therapy may not be well-suited for private practice behavioral health services. In some cases, co-occurring substance use disorders, unmanaged medical conditions, or cognitive impairments may interfere with the effectiveness of therapy and require additional or alternative treatment modalities.

A thorough clinical assessment will be conducted to determine whether behavioral health treatment in a private practice setting is appropriate for your individual needs. Recommendations for a higher level of care may be made if it is determined that behavioral therapy alone is unlikely to provide the level of support and intervention necessary for your safety and well-being.

Alternative Treatments

If private/outpatient behavioral health treatment is determined to be inappropriate or insufficient to meet your clinical needs, there are several alternative levels of care and therapeutic interventions available. Alternatives include, but may not be limited to: inpatient psychiatric care, partial hospitalization programs, intensive outpatient programs, residential treatment facilities, or medication management with a psychiatrist. Although it is important to remember that each alternative comes with its own scope of care, risks, benefits, and eligibility criteria.

Financial Responsibility

The cost of your treatment can vary depending on the type of services provided, the length of sessions, and the specific provider. Insurance coverage may help offset some of these costs, but the extent of coverage varies between plans. It is essential to check with your insurance company to understand what services are covered, any co-payments, deductibles, and out-of-pocket maximums.

Billing statements will be provided for the services rendered, and it is your responsibility to review these statements carefully. Any charges not covered by insurance will be billed directly to you. Payment arrangements should be discussed with our billing department if you have concerns about your ability to pay.

You are responsible for any costs not covered by insurance, including co-pays, deductibles, and charges for missed or canceled appointments. If there are changes to your insurance coverage or financial situation, please inform us promptly to ensure your billing information is accurate and up-to-date. If you have questions about billing or need assistance, our office staff is available to help clarify any issues and discuss payment options.

Informed Consent

BY SIGNING THE E-VERSION OF THIS YOU ARE CONSENTING TO THE BULLET POINTS BELOW AND E-SIGNATURE INDICATED THE SAME CONSENT AS INITIALLING

_____ (*Patient/Representative Initials*) I have received, reviewed, and understand this consent form and have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

_____ (*Patient/Representative Initials*) I certify that I have read, or have had read to me, the contents of consent form.

_____ (*Patient/Representative Initials*) I understand the potential risks associated with behavioral and mental health treatment in a private practice/outpatient setting and understand that results may vary and cannot be guaranteed.

_____ (*Patient/Representative Initials*) I understand that I have the right to make decisions about the behavioral and mental health care that I receive, that I can refuse behavioral and mental health care at any time, and that I can revoke this consent at any time (except to the extent services have already been provided).

_____ (*Patient/Representative Initials*) Contraindications and alternative treatment options have been fully explained to me.

_____ (*Patient/Representative Initials*) I understand that to the extent my care is not covered by my insurance, that I will be fully financially responsible for the cost of my treatment.

_____ (*Patient/Representative Initials*) I consent and authorize the practice and its providers to provide me with behavioral and mental health treatment and care.

_____ (*Patient/Representative Initials*) I understand that the practice reserves the right to determine at any time that it is not appropriate for me to receive services. I understand that in such event, the practice will notify me of this decision and I will be provided with resources for accessing alternative and more appropriate mental health care services.

I certify that I have read and fully understand the statements above on all pages and I consent fully and voluntarily to its contents.

GRIEVANCE POLICY:

The Stable Mind, PLLC

Saegertown, PA

814-261-2758

GRIEVANCE POLICY

(for behavioral/mental health)

Effective Date: 7/31/25

At THE STABLE MIND, PLLC (the “Practice”), we are committed to delivering compassionate and quality behavioral and mental health services in a safe and respectful environment. As part of this commitment, we have established a clear and accessible Grievance Policy to ensure that any concerns or complaints that you may have are addressed promptly, fairly, and without retaliation. This policy outlines your rights, the steps to file a grievance, and how we work to resolve any such issues. If you need help completing this form or require it in another language or format, please let our staff know.

1. Purpose

The purpose of this Grievance Policy is to provide a clear, fair, and confidential process for clients, their representatives, and staff to express concerns or complaints related to treatment, rights, staff conduct, or other aspects of care at the Practice.

2. Policy Statement

The Practice is committed to providing the highest quality care in an ethical and respectful manner. Every client has the right to express dissatisfaction without fear of retaliation, and to have grievances addressed promptly and equitably. This policy outlines the procedures to ensure that all grievances are handled in a timely, confidential, and sensitive manner.

3. Scope

This policy applies to:

- All clients and their legal representatives
- All employees, contractors, and interns of the Practice
- All services provided on-site, virtually (telehealth), or off-site (e.g., home visits)

4. Definitions

“Grievance”: A formal or informal complaint expressed by a client or their representative regarding dissatisfaction with services, treatment, policies, interactions with staff, or perceived violations of rights.

“Client Representative”: A parent, guardian, or legal representative acting on behalf of a minor or an individual with legal decision-making assistance.

“Resolution”: An action or outcome that addresses the grievance to the extent possible and within legal and ethical boundaries.

5. Client Rights

Clients have the right to:

- Be informed of this grievance policy upon intake and annually thereafter.
- File a grievance without fear of discrimination, coercion, or retaliation.
- Receive assistance in filing a grievance if needed, including language interpretation and disability accommodation.
- Receive a written response, including findings and resolution steps.
- Appeal the decision if dissatisfied with the outcome.
- File a complaint with state or federal oversight agencies (such as the Department of Health, licensing board, Medicaid office, etc.) if they are not satisfied with the outcome of an internal grievance. Contact information will be provided upon request or included on the practice website.

Filing a grievance will not affect your access to care or the quality of services you receive at the Practice.

6. Procedures for Filing a Grievance

Step 1: Informal Resolution (Optional)

Clients are encouraged to first attempt informal resolution by discussing concerns directly with their provider or the staff member involved. If the issue is unresolved or if the client prefers, a formal grievance may be filed at any time.

Step 2: Formal Grievance Submission

Grievances may be submitted:

- In writing, using the Grievance Form available in the office (also attached here as *Addendum A*), via the practice website, or upon request.
- Verbally, in person or by phone, to any staff member of the Practice, who will document the grievance in writing.
- By email or secure portal, where available.

Grievances should be directed to the Practice's Grievance Coordinator, whose name and contact information is listed at the end of this form.

The grievance should include, at a minimum, the following information:

- The client's name and contact information (email address and phone number)
- Description of the grievance (dates, persons involved, and nature of the concern)
- Desired outcome or resolution

Anonymous grievances may be submitted but may limit our ability to fully investigate or respond to the concern. All efforts will be made to address such concerns in good faith.

Step 3: Acknowledgment of Receipt

The Grievance Coordinator will:

- Acknowledge receipt of the grievance in writing within 3 business days
- Log the grievance in the confidential grievance tracking system

7. Investigation and Resolution

Timeline

The grievance will be investigated and resolved within 30 calendar days of receipt.

If additional time is needed, the client will be notified in writing with an explanation and revised timeline.

Investigation Process

- Review of documentation and treatment records
- Interviews with involved staff or witnesses
- Consultation with legal or clinical advisors as appropriate
- Assessment of relevant policies and procedures

Resolution

The client will receive a written response summarizing:

- The findings of the investigation
- Actions taken or planned (e.g., staff training, policy changes, disciplinary measures)
- Appeal options

All actions will be documented in the grievance log and maintained in a confidential file.

8. Appeals Process

If the client is not satisfied with the resolution, they may file a written appeal within 15 calendar days of receiving the outcome.

The appeal will be reviewed by a higher-level administrator or an impartial third party not involved in the original grievance. The Grievance Coordinator will acknowledge receipt of the appeal in writing within 3 business days of receipt.

The appeal review will be completed within 15 calendar days, and a final decision will be communicated in writing. If additional time is needed, the client will be notified in writing with an explanation and revised timeline.

9. Confidentiality

All grievances and related investigations will be kept confidential, to the extent permitted by applicable law. Only those directly involved in the grievance process will have access to related information.

Client records related to grievances are maintained separately from the clinical record and stored securely in accordance with HIPAA.

10. Non-Retaliation

Retaliation in any form against a person who files a grievance, cooperates in an investigation, or appeals a decision is strictly prohibited and may result in disciplinary action, up to and including termination of employment.

11. Recordkeeping and Reporting

A log of all grievances, investigations, and outcomes will be maintained by the Grievance Coordinator for a minimum of six (6) years or as otherwise required by applicable state laws.

Reports summarizing grievance trends (de-identified) may be reviewed quarterly to inform quality improvement and risk management efforts.

12. Accessibility and Communication

This policy shall be posted in a visible location in the practice and made available on the practice website.

Clients will be informed of their rights and this grievance policy at intake and annually thereafter.

Copies will be available in alternative languages or formats upon request.

13. Grievance Process for Minors

At the Practice, we recognize that minors (individuals under the age of 18) receiving behavioral and mental health services have unique rights and needs. The Practice is committed to ensuring that minors, along with their parents or legal guardians, understand their rights and have access to a clear, supportive grievance process.

Rights of Minors in Treatment

Minors receiving care at the Practice have the right to:

- Be treated with respect, dignity, and compassion, regardless of age.

- Participate in their treatment planning to the extent appropriate for their age, maturity, and clinical condition.

- Express concerns or complaints about their care without fear of punishment or retaliation.

- Expect that any concerns they raise will be taken seriously and addressed in a timely and confidential manner.

Depending on the minor's age, applicable state law, and the type of services being provided, minors may also have specific rights to consent to treatment or to confidentiality of certain health information.

Filing a Grievance on Behalf of a Minor

A grievance may be submitted:

- By the minor, if capable and appropriate;
- By a parent or legal guardian;
- Jointly by the minor and their parent/guardian; or
- By an authorized representative acting on behalf of the minor.

The grievance may be submitted in writing, verbally, or electronically using the same channels outlined in the general grievance process above.

Evaluation of Grievances Involving Minors

When a grievance involves a minor:

- The Practice will consider the best interests of the minor while also respecting applicable laws regarding confidentiality and consent.
- If a minor submits a grievance independently, the Practice will evaluate whether parental involvement is appropriate or required by law.
- Confidentiality protections will be honored according to state and federal law, including specific protections for certain types of treatment such as substance use, reproductive health, or mental health counseling.

Resolution Process

Grievances involving minors will be reviewed and resolved following the standard grievance process timeline described above. In addition:

- The minor and their parent/guardian (when appropriate) will be informed of the resolution in an appropriate and clear manner.
- If additional protective or supportive steps are needed (such as involving child welfare or adjusting the treatment plan), these actions will be taken with sensitivity and in compliance with applicable laws.

Support and Advocacy

Minors and their families may request assistance from a Patient Advocate or Client Rights Officer (if applicable) to support them in the grievance process. The Practice will make reasonable accommodations to help minors understand and participate in the process, including offering age-appropriate explanations and access to interpreters or other support services.

14. Contact Information for Grievances

Grievance Coordinator Name: Dallas Acker

Title: CEO, PMHNP-BC

Phone: 814-261-2758

Email: dallas@thestablemind@gmail.com

Mailing Address: n/a

Website: n/a

IF YOU NEED TO FILE A GRIEVANCE, PLEASE USE THE TEMPLATE BELOW TO SEND TO THE CONTACT INFO ABOVE. THANK YOU

ADDENDUM A

Patient Grievance Form

We are committed to providing quality care and addressing any concerns you may have. Please use this form to share your grievance so we can respond appropriately.

Date of Submission: _____

Patient Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Mailing Address: _____

Preferred Contact Method: Phone Email Mail

Description of Grievance: *(Please describe the issue or concern in detail, including any dates, names of staff involved, or specific incidents. Attach additional pages if necessary.)*

Have you discussed this concern with a staff member?

Yes – Name of staff member: _____

Date of discussion: _____

No

If yes, what was the outcome?

What would you like to see as a resolution to this grievance?

Patient/Representative Signature: _____

Relationship to Patient (self, parent, guardian, etc.): _____

Print Name: _____

Date: _____

PATIENT RIGHTS AND RESPONSIBILITIES:

The Stable Mind, PLLC

Saegertown, PA

814-261-2758

STATEMENT OF PATIENT RIGHTS & RESPONSIBILITIES

(for behavioral/mental health)

Effective Date 7/31/25

At THE STABLE MIND, PLLC (the “Practice”), we are committed to providing the highest quality behavioral health services in an environment that respects your dignity, privacy, and autonomy. This Statement of Patient Rights & Responsibilities outlines what you can expect from us —and what we expect from you — as a partner in your care. This document may be updated periodically. You will be notified of any significant changes. If you have any questions regarding this document, please inform us. If you need this form in another language or accessible format, please let us know.

PATIENT RIGHTS

-

As a patient of the Practice, you have the right to:

1. Respect and Non-Discrimination

You have the right to be treated with respect, dignity, and compassion regardless of race, color, national origin, religion, sex, gender identity or expression, sexual orientation, age, disability, socioeconomic status, or any other legally protected status.

You have the right to receive behavioral health services free from harassment, neglect, or exploitation.

2. Access to Care

-

You have the right to receive timely access to appropriate behavioral health care based on your clinical needs.

You have the right to refuse treatment or services and be informed of the consequences of such refusal.

3. Confidentiality and Privacy

You have the right to have your personal and medical information kept confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA), applicable state privacy laws, and the ethical standards of behavioral health professionals.

You have the right to request a copy of your medical records and to request amendments or corrections to your health information as permitted by law. To do so, you may submit a written request to the Practice. We will respond to your request in accordance with applicable state and federal regulations, including the timeframes and procedures outlined in HIPAA.

You also have the right to be informed about the limits of confidentiality, including the legal and ethical circumstances under which your provider may be required to share protected

information without your consent. Specifically, your provider is mandated by law to break confidentiality in the following situations:

- If there is reasonable suspicion of abuse or neglect of a child, dependent adult, or elderly person

- If you disclose a serious intent to harm yourself or another identifiable person, and the provider believes there is imminent risk

- If a court issues a valid subpoena or court order requiring the release of your records

- If required for certain legal, licensing, or public health purposes, as governed by applicable law

In these situations, disclosures are limited to what is necessary to protect your safety or the safety of others and to comply with legal obligations. Whenever possible, and unless it increases risk of harm, you will be informed if such a disclosure is made.

4. Participation in Treatment Planning

You have the right to be an active participant in developing, reviewing, and revising your treatment plan.

You have the right to be informed in understandable language about the nature of your condition, recommended treatments, alternatives, risks and benefits, and expected outcomes.

You have the right to involve family members or other people of your choice in your care, if you wish to do so and if clinically appropriate.

5. Informed Consent

You have the right to receive sufficient information to make an informed decision about your care, including the nature and purpose of proposed treatment, risks and benefits, and alternative approaches.

You have the right to withdraw consent or discontinue treatment at any time.

6. Communication

You have the right to be provided with information in a manner that you can understand, including access to language translation or interpretation services if needed.

You have the right to ask questions and receive clear answers regarding your care and services.

7. Safety and Dignity

You have the right to receive care in a safe and secure environment.

You have the right to be free from physical, emotional, sexual, and financial abuse or exploitation.

You have the right to file a grievance or complaint without fear of retaliation or interference with your care and to receive a timely response. In the event you would like to file a formal grievance or complaint, you should refer to the Practice's Grievance Policy.

8. Financial Transparency

You have the right to receive a clear explanation of fees, billing practices, insurance coverage, and your financial obligations prior to the start of treatment.

You have the right to request an itemized bill and an explanation of charges.

9. Continuity of Care

-

You have the right to receive referrals or continuity of care when your therapist is unavailable, upon discharge, or if you choose to transition care.

10. Advance Directives

You have the right to create and maintain an advance mental health directive, in accordance with applicable state and federal laws. An advance mental health directive is a legal document that allows you to express your preferences for future mental health treatment, including medications, hospitalization, and crisis interventions, in the event that you become unable to make or communicate decisions during a mental health crisis.

The Practice will honor valid and applicable advance directives to the extent required by law and consistent with clinical judgment and ethical standards. If you have an existing mental health advance directive, you are encouraged to provide a copy to the Practice so that it can be included in your medical record and considered in your care planning.

If you do not have an advance directive and would like information or assistance in creating one, please notify your provider or administrative staff. We will provide you with resources or referrals to help you understand your rights and the options available to you.

11. Telehealth

You have the right to receive services via telehealth, where appropriate and legally permitted, and to be informed of the risks and benefits of remote care, including potential risks to privacy. The Practice uses secure, HIPAA-compliant platforms for telehealth sessions to protect your confidentiality. However, no electronic communication is entirely risk-free, and by choosing to engage in telehealth services, you acknowledge and accept those inherent limitations.

Rights of Minor Patients

-

Minor patients (individuals under the age of 18) receiving behavioral health services are entitled to many of the same rights as adult patients, with additional considerations for their developmental needs and legal status. The rights of minor patients include:

1. Respect and Dignity: The right to be treated with respect, compassion, and dignity regardless of age, background, or presenting concern.
2. Participation in Treatment: The right to participate in decisions regarding their care to the extent appropriate for their age, maturity, and cognitive ability. This includes being informed in developmentally appropriate language about their condition, proposed treatments, and expected outcomes.
3. Confidentiality: The right to confidentiality of their treatment and records, with age-appropriate limitations. While parents or guardians typically have access to a minor's treatment records, certain disclosures may be limited in accordance with state laws,

especially concerning sensitive services such as mental health, substance use, or reproductive health.

4. Privacy: The right to privacy during treatment sessions, unless there is a safety concern or a therapeutic reason for involving others.
5. Safety and Protection: The right to receive services in a safe, secure, and non-threatening environment, free from physical or emotional abuse, neglect, or exploitation.
6. Freedom from Coercion: The right not to be forced or unduly influenced to participate in treatment decisions or to undergo any procedure against their will, to the extent allowed by law.
7. Right to a Support Person: The right to have a parent, legal guardian, or other appropriate support person involved in care, except where confidentiality protections apply or where it is therapeutically contraindicated.
8. Access to Education: The right to continued access to education while receiving behavioral health services in an extended treatment setting, as applicable.
9. Grievances: The right to express concerns or grievances about their treatment and to have those concerns addressed promptly and without retaliation.
10. Cultural and Personal Beliefs: The right to have their cultural, spiritual, and personal values respected in the treatment process.

Parents or legal guardians also retain specific rights related to the treatment of the minor, including being informed of and consenting to treatment where required, accessing records (subject to applicable laws), and participating in treatment planning. The balance between a minor's right to privacy and a parent's right to know will be managed in

accordance with federal and state laws, clinical judgment, and best practices for promoting the minor's well-being.

PATIENT RESPONSIBILITIES

To support a safe and effective therapeutic relationship, you are expected to:

1. Honesty and Disclosure

You are expected to provide accurate and complete information about your health history, symptoms, medications, and relevant life circumstances.

You are expected to notify your provider of any changes to your health, medication regimen, or contact information.

2. Participation in Treatment

You are expected to collaborate actively in the treatment process, including attending scheduled appointments on time and engaging in agreed-upon interventions.

You are expected to discuss concerns openly with your provider and participate in decision-making.

3. Respect and Civility

You are expected to treat staff, providers, and other patients (if in a group setting) with courtesy and respect.

You are expected to avoid aggressive, threatening, or disruptive behavior.

4. Confidentiality of Others

You are expected to respect the privacy and confidentiality of other individuals you may encounter in group therapy or shared spaces.

5. Financial Obligations

You are expected to pay co-pays, fees, and balances in a timely manner, and notify the office if you experience financial hardship that may affect your ability to pay.

You are expected to provide accurate insurance information and notify the office of any changes in coverage.

6. Appointment Attendance

You are expected to arrive on time for appointments and provide at least 24 hours' notice for cancellations or rescheduling.

You are expected to understand that repeated no-shows or late cancellations may result in a fee or termination of care.

7. Medication Compliance

You are expected to take prescribed medications as directed and discuss any concerns or side effects with your provider.

8. Safety

You are expected to inform your provider if you are experiencing a crisis or any thoughts of harming yourself or others. If you are experiencing a medical or mental health emergency, please call 911 or go to the nearest emergency room. The Practice is not equipped to provide emergency services. You may also contact a local crisis line or the National Suicide & Crisis Lifeline at 988.

You are expected to refrain from bringing weapons, drugs, or alcohol onto the premises.

9. Telehealth

You are expected to use the designated communication platforms responsibly and to ensure your own privacy when engaging in telehealth sessions.

Filing a Complaint

-

If you feel your rights have been violated, you may:

- File a formal grievance with the Practice (please refer to the Practice's Grievance Policy). You can also contact the Practice's compliance officer or clinical director at:

o Phone:814-261-2758

o Email: dallas@thestablemind@gmail.com

o Mailing Address: n/a

- File a complaint with the U.S. Department of Health and Human Services Office for Civil Rights if you believe your privacy rights have been violated.

- Contact your state's behavioral health regulatory board or licensing agency.

Patient Acknowledgment and Signature

By signing below, I acknowledge that: YOUR E-SIGNATURE INDICATES YOU AGREE WITH THE FOLLOWING:

- I have received, reviewed, read in full (or have had read to me) this Statement of Patient Rights and Responsibilities from the Practice.

- I understand my rights as a patient and my responsibilities in receiving behavioral and mental health services.

- I have had the opportunity to ask questions about this document and understand the information provided to me.

- I understand that I may request a copy of this document for my records.

- I agree to abide by the responsibilities outlined and understand the potential consequences of non-compliance, including termination of services where appropriate.

- I understand that this acknowledgment is not a waiver of my rights, but a confirmation that I have been informed of them.

CONSENT TO TELEHEALTH:

The Stable Mind, PLLC

Saegertown, PA

814-261-2758

TELEHEALTH CONSENT FORM

(for behavioral/mental health)

The purpose of this form is to explain what telehealth is, how it is used for your behavioral and mental health services, the risks involved, and to obtain your consent for treatment by

telehealth. Please read through this form in its entirety and let us know if you have any questions before proceeding with any telehealth visits.

About Telehealth

Telehealth allows you to receive behavioral and mental health services remotely using secure video calls, phone calls, or messaging instead of meeting in person at a clinic or office. During a telehealth session, you and your provider will connect in real time through a computer, tablet, or smartphone, allowing you to engage in therapy from the comfort of your home or another private location.

Behavioral telehealth sessions may include individual therapy, couples or family counseling, or other forms of talk therapy. These sessions focus on identifying and addressing emotional, psychological, and behavioral challenges such as anxiety, depression, stress, trauma, relationship issues, and life transitions. Your provider will work with you to explore thoughts and feelings, build coping strategies, develop goals, and support positive behavioral changes. The care you receive is comparable in quality to in-person therapy and is tailored to your individual needs.

Telehealth is a convenient and effective way to access behavioral health care, but it does depend on reliable technology. You are responsible for having access to a computer, smartphone, or tablet with a stable internet connection, and ensuring your device is set up with any necessary software or applications prior to each session. At the start of each session, you may be asked to confirm your physical location and an emergency contact, to ensure your provider can respond appropriately in a crisis.

Benefits and Risks

The use of telehealth comes with certain benefits, which include, but may not be limited to:

- *Convenience.* You can talk to your provider from the comfort of your home or another location, without having to travel to the clinic. This can save you time and effort, especially if you have mobility issues or live far away.
- *Access to Care.* Telehealth allows you to get care more quickly, especially if in-person appointments at the clinic are limited.
- *Flexibility.* Telehealth offers more flexible scheduling options, which can make it easier to arrange appointments.
- *Continuity of Care.* Telehealth enables ongoing care even when circumstances make it difficult to meet in person, such as during illness, travel, or pandemic restrictions.
- *Increased Privacy.* Some patients may feel more comfortable discussing sensitive topics from the privacy of their own space.
- *Reduced Wait Times.* Telehealth may provide quicker access to care, as geographical barriers are minimized.

The use of telehealth comes with certain risks as well, which include, but may not be limited to:

- *Technology Issues.* There may be times when your telehealth visit is interrupted by poor internet connections, software glitches, or other technical problems. This can make it harder for your provider to understand your condition or may delay the appointment. In the event of technical difficulties that disrupt the session, you may be contacted by phone or rescheduled for a follow-up appointment. The provider is not liable for any issues related to your technology or internet connection.

- *Limitations of Virtual Care.* You and your provider won't physically be in the same room, so it may feel different than an office visit. The provider cannot physically examine you, which might limit the ability to assess certain conditions fully. In addition, non-verbal cues might be harder to interpret through video or phone, which could affect diagnosis or treatment quality.

- *Privacy and Security.* While your provider will use secure systems to protect your medical information, there is a small chance that your data could be accessed by unauthorized people, such as through hacking or other breaches, though this is rare. To protect your privacy, we strongly recommend not using public Wi-Fi for your sessions and ensuring your device is password protected.

- *Emergency Situations.* Telehealth may not be suitable for emergencies or severe behavioral conditions that require immediate or in-person intervention. You should understand that telehealth is NOT appropriate for medical emergencies. In the event of an emergency, you should immediately call 911 or go to the nearest emergency room. If an emergency situation arises during a telehealth session, your provider may be required to alert local authorities or emergency response personnel for intervention.

Privacy of Telehealth Visits

The laws that protect privacy and the confidentiality of medical information also apply to telehealth. All telehealth services are provided in accordance with HIPAA and any applicable federal or state privacy laws governing behavioral and mental health information. Telehealth sessions may generate psychotherapy notes, which are kept separate from your medical record and are subject to enhanced privacy protections under HIPAA. These notes will not be disclosed without your specific written authorization, except as may be required or permitted by applicable law.

Your telehealth visit will be private, and we take steps to protect your confidentiality, but you should understand that that no technology is completely risk-free.

- We will not record your visits with the provider.

- If people are nearby, they may overhear something you did not want them to know. To protect your privacy, it's important to be in a private, quiet place where others cannot hear you.
- Your provider will inform you if anyone else from their office can hear or see you during the visit.
- We use secure telehealth technology designed to protect your privacy and keep your information safe.
- When using telehealth, it's important to use a private and secure internet connection to ensure your information stays confidential.
- Although we take many precautions, there is a very small chance that someone could use technology to access or overhear your telehealth visit, though this is rare.

-

Right to Withdraw

-

You have the right to stop using telehealth services at any time, for any reason. If you decide that you no longer wish to receive care through telehealth, then you can let your provider or the practice know by calling us at 814-261-2758 or sending a written notice to the practice address at: dallas@thestablemind@gmail.com.

Stopping telehealth services will not affect your access to other types of care or your relationship with your provider. You can always choose to schedule an in-person visit instead of using telehealth if you prefer. If you withdraw from telehealth, your provider will discuss other options for continuing your care, which may include in-office visits or referrals to other healthcare providers. There are no penalties for choosing to withdraw from telehealth services.

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Alternative Options

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Participation in telehealth is completely voluntary. You are not obligated to use telehealth, and you have the option be seen in-person at the clinic.

Cost

You are responsible for the full cost of your telehealth visit, including any fees not covered by your insurance plan. The cost of a telehealth session is generally the same as a traditional in-person office visit. Your specific out-of-pocket expenses may vary depending on your insurance coverage, copayments, deductibles, and benefits. It is your responsibility to verify your mental health benefits with your insurance provider before your session. If your provider determines that an additional in-person visit is necessary to support your care, you may be billed separately for each visit. Any services not covered by insurance, or visits conducted without insurance, will be your financial responsibility. If you have questions about billing or payment, please contact the office prior to your appointment.

Patient Acknowledgements-YOUR E-SIGNATURE INDICATES YOU ARE IN AGREEMENT WITH THE FOLLOWING AREAS REQUIRING INITIALS. YOUR E-SIGNATURE IS REPLACING INITIALS.

_____ (*Patient/Representative Initials*) I have received, reviewed, and understand this consent form. I certify that I have read, or have had read to me, the contents of consent form.

_____ (*Patient/Representative Initials*) I have been informed about the nature of telehealth services, including the risks and benefits, and I voluntarily consent to use telehealth for my behavioral and mental health care.

_____ (*Patient/Representative Initials*) I have had the opportunity to ask any questions that I may have. All of my questions have been answered to my satisfaction.

_____ (*Patient/Representative Initials*) I understand the potential benefits of telehealth and acknowledge that results cannot be guaranteed.

_____ (*Patient/Representative Initials*) I authorize my provider to contact my listed emergency contact if a crisis or emergency arises during or after a telehealth session, or if the provider determines that my safety or the safety of others is at risk.

_____ (*Patient/Representative Initials*) I understand that my consent is voluntary, and I may opt out of telehealth and withdraw my consent at any time. My decision to not use telehealth will not affect my ability to receive future care.

_____ (*Patient/Representative Initials*) I consent to receiving communications related to my telehealth services via electronic means, including appointment reminders, follow-up information, and other relevant updates.

_____ (*Patient/Representative Initials*) I understand that the laws, ethics and professional standards that apply to in-person behavioral and mental health services also apply to services delivered by telehealth. This consent form does not replace or supersede any other agreements, contracts, or consent forms signed by me that may cover other aspects of my healthcare.

I certify that I have read and fully understand the statements above on all pages and I consent fully and voluntarily to its contents. I authorize the provider to use telehealth in the course of providing my behavioral, mental health, and medical care, and related treatments and diagnoses.

OUTPATIENT PSYCH WAIVER:

The Stable Mind, PLLC

Saegertown, PA

814-261-2758

OUTPATIENT PSYCHIATRY

WAIVER & RELEASE OF LIABILITY

I, _____ (*print name*), acknowledge that outpatient psychiatric treatment involves various medical and therapeutic interventions. While the Practice takes reasonable steps to ensure my safety, I understand that mental health treatment carries inherent risks, including but not limited to, emotional distress, medication side effects, interpersonal conflicts, ineffective treatment response, changes in symptoms, and need for crisis intervention. I recognize that outpatient care does not provide continuous supervision, and I am responsible for seeking emergency care or additional support if my condition worsens. I voluntarily and fully assume all risks, regardless of severity, that I may sustain in connection or associated with the outpatient psychiatric care provided to me by the Practice. I, for myself and my heirs, assigns, personal representatives, and next of kin, expressly waive and release any and all claims, now known or hereafter known, against the Practice and its successors, assigns, employees, contractors, officers, directors, agents, affiliates, subsidiaries, and parent company, each and all of them (collectively, the "Releasees"), on account of personal injury or property damage arising out of or relating to my voluntary outpatient psychiatric care at the Practice. I will not to make or bring any such claim against any Releasee, and forever release and discharge all Releasees from any and all liability under such claims. All matters arising out of or relating to this waiver and release will be governed by and construed in accordance with the laws of the State of Practice's address as listed above (the "State"), without giving effect to any choice or conflict of law provision or rule. Any claim or cause of action arising under this waiver and release may be brought only in the federal and state courts located in the city and State of the Practice's address as listed above, and I consent to the exclusive jurisdiction of such courts. I understand that this waiver and release is intended to be as broad and inclusive as permitted by law and that if any portion hereof is held invalid, I agree that the remainder will continue in full legal force and effect. I further agree that if this waiver and release is not valid as such in the State, then it will be construed as a covenant not to sue.

I acknowledge that at the time of signing this form, I am of sound mind and capable of making independent decisions for myself. I HAVE READ THIS WAIVER AND RELEASE AND UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT. I AM SIGNING THIS WAIVER AND RELEASE VOLUNTARILY.

YOUR E-SIGNATURE INDICATES YOU ARE IN AGREEMENT WITH ALL OF THE ABOVE REGARDING OUTPATIENT WAIVER

Controlled Substance Medication Agreement

Purpose:

Controlled medications (such as stimulants, benzodiazepines, or other scheduled prescriptions) can be effective for certain conditions, but they also carry risks of misuse, dependence, and diversion. This agreement outlines the responsibilities of both you (the patient) and me (your prescriber) to ensure safe and effective use of these medications. By signing, you acknowledge and agree to the following:

1. Follow-Up and Monitoring

- I agree to attend all follow-up visits as scheduled by my provider.
- I understand that follow-up requirements may include:
 - Urine drug screening (UDS) at any time.
 - EKGs, blood pressure checks, or lab work as requested.

- Follow-up with my primary care provider (PCP) as recommended.
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- I understand that refills will not be provided if I miss required monitoring or follow-up.

2. Early Refills and Replacement

- Early refills will not be provided under any circumstance.
- If my medication is lost, stolen, or destroyed, it will not be replaced early.

3. Communication of Health Concerns

- I agree to disclose all health conditions and changes in my health to my provider.
- If I fail to disclose important health information, I accept responsibility for any resulting complications.

4. Purpose of Controlled Medications

- Controlled medications are prescribed only for the condition being treated.
- I will not adjust the dose or frequency on my own. All changes must be discussed with and approved by my provider.

5. Safe Use

- I will take my medication exactly as prescribed.
- I will not use my medication for any illegal or nonmedical purpose.
- I will not share, sell, or give away my medication to anyone.

6. Storage and Security

- I will keep my medication in a safe, secure location at all times.
- I understand that my provider will not replace lost, stolen, or destroyed medication early.

7. Pharmacy Use

- I will use only one pharmacy for all controlled medication prescriptions unless otherwise approved by my provider.

8. Monitoring and Verification

- My provider may check prescription monitoring programs (PMPs) to verify where and how my medications are being filled.
- My provider may follow up to ensure I am taking my medications appropriately.

9. Termination Clause

- I understand that violation of any part of this agreement, including evidence of misuse, diversion, abuse, or failure to comply with monitoring, may result in:
 - Discontinuation of controlled substance prescriptions.
 - Referral to other treatment options.
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Acknowledgement:

I have read and understand this agreement. I agree to follow these policies for my safety and to ensure effective treatment. I understand that failure to follow this agreement may result in discontinuation of controlled substance treatment.

Authorization for Release of Information (ROI)

Practice Name: The Stable Mind, PLLC

Provider: Dallas Acker, PMHNP-BC

Phone: 814-261-2758

Email: Dallas.thestablemind@gmail.com

I hereby authorize The Stable Mind, PLLC to release and/or obtain the following information:

- Evaluation Reports
- Medication Records
- Progress Notes
- Diagnosis
- Treatment Plans
- Other: _____

This information may be disclosed to or obtained from: PCP and other healthcare providers

Purpose of Disclosure:

- Coordination of Care
- Legal
- Disability/SSDI
- FMLA
- Personal Use
- Other: _____

I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken.