# COMPREHENSIVE PATIENT CONSENT FOR SERVICES DURING TRANSITION PERIOD

## I. PURPOSE AND ORGANIZATIONAL STRUCTURE DISCLOSURE

Alexandra Gleason, LMFT, PLLC d/b/a North Shore Relationship Center ("NSRC") has been acquired by CS Medical Associates, P.C. d/b/a Victory Recovery Partners ("Victory"). During this transition period, services are being integrated across affiliated entities.

During this time:

- Therapy services will be provided through NSRC
- Psychiatric evaluation and medication management services, if clinically indicated, will be provided by licensed psychiatric providers affiliated with Victory

These entities are legally distinct, but are collaborating to ensure:

- Continuity of care
- Timely access to services
- Integrated clinical treatment

I understand that I may receive services from one or both entities depending on my clinical needs.

## II. CONSENT TO PARTICIPATE IN TREATMENT

I, ________________________________________ (patient name), voluntarily consent to participate in mental health treatment services, which may include:

- Diagnostic evaluation
- Individual, family, or group therapy
- Care coordination
- Referral to psychiatric services, if clinically indicated

I understand that:

- Participation in treatment is voluntary
- I may withdraw from treatment at any time, subject to clinical recommendations and safe discharge planning
- I have the right to ask questions and receive information about my treatment at any time
- No guarantees have been made regarding outcomes

## III. NATURE OF THERAPY SERVICES

I understand that therapy involves the assessment and treatment of emotional, behavioral, and psychological conditions.

Potential risks may include:

- Emotional discomfort
- Recollection of distressing experiences
- Temporary worsening of symptoms

Potential benefits may include:

- Improved coping skills
- Symptom reduction
- Improved relationships and functioning

I understand that my progress depends in part on my active participation.

## IV. REFERRAL TO PSYCHIATRIC SERVICES

If clinically appropriate:

- I may be referred for psychiatric evaluation and/or medication management
- These services may be provided by CS Medical Associates, P.C. d/b/a Victory Recovery Partners, which is a separate legal entity

I understand that:

- Participation in psychiatric services is voluntary
- I will be required to complete a separate informed consent for psychiatric evaluation and medication management prior to receiving those services

## V. HIPAA ACKNOWLEDGMENT AND AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that my protected health information ("PHI") is protected under the Health Insurance Portability and Accountability Act and applicable New York State laws.

### A. Acknowledgment of Privacy Practices

I acknowledge that:

- I have received or have been offered a copy of the Notice of Privacy Practices
- The Notice explains how my health information may be used and disclosed
- I have the right to ask questions regarding these practices

### B. Use and Disclosure for Treatment, Payment, and Healthcare Operations

I understand that my health information may be used and disclosed, without additional authorization, for purposes of:

- Treatment
- Payment
- Healthcare operations

### C. Authorization for Inter-Entity Sharing

I specifically authorize the use and disclosure of my health information between:

- Alexandra Gleason, LMFT, PLLC d/b/a North Shore Relationship Center
- CS Medical Associates, P.C. d/b/a Victory Recovery Partners

for purposes of:

- Coordination of care
- Diagnosis and treatment
- Referral and consultation
- Billing and healthcare operations related to my care

I understand that:

- These entities are separate legal organizations
- This authorization is necessary to ensure continuity and integration of my care

### D. Sensitive Information Disclosure

I understand that this authorization may include disclosure of sensitive information, including but not limited to:

- Mental health information
- HIV/AIDS-related information
- Alcohol and substance use information (to the extent applicable)
- Sexually transmitted diseases
- Genetic testing information

Such information will be disclosed only as permitted by applicable federal and New York State laws.

### E. Right to Revoke

I understand that:

- I may revoke this authorization at any time in writing
- Revocation will not apply to information already disclosed
- Revocation may impact the ability of providers to coordinate my care

## VI. TELEHEALTH CONSENT

I understand that services may be provided via telehealth, which involves communication through electronic systems.

I acknowledge that telehealth may include risks such as:

- Technical failures
- Interruptions
- Potential unauthorized access, despite reasonable safeguards

I understand that:

- Telehealth is voluntary
- I may withdraw consent at any time
- I am responsible for being in a private, safe environment during sessions

In the event of an emergency, I agree to call 911 or go to the nearest emergency room.

## VII. FINANCIAL RESPONSIBILITY AND BILLING DISCLOSURE

### A. Separate Billing Entities

I understand that:

- Therapy services will be billed through NSRC
- Psychiatric services, if provided, may be billed through CS Medical Associates, P.C. d/b/a Victory Recovery Partners
- I may receive separate bills depending on services rendered

### B. Insurance and Payment Responsibility

I agree that I am responsible for:

- Copayments

- Coinsurance
- Deductibles
- Non-covered services

I understand that:

- Insurance coverage is not guaranteed
- I am financially responsible for any balance not paid by insurance

### C. Assignment of Benefits

I authorize:

- Release of necessary information to insurance carriers
- Direct payment of benefits to the provider/entity rendering services

## VIII. LIMITS OF CONFIDENTIALITY

I understand that confidentiality may be limited in situations including, but not limited to:

- Risk of harm to myself or others
- Suspected abuse or neglect
- Court orders or legal requirements

Providers may be required to disclose information in accordance with applicable laws.

## IX. RECORDS AND DOCUMENTATION

I understand that:

- My medical record will be maintained securely
- Records will be retained in accordance with New York State requirements
- I may request access to my records in accordance with applicable law

## X. VOLUNTARY CONSENT AND RIGHT TO REVOKE

I understand that:

- This consent is voluntary
- I may revoke this consent at any time in writing, except where action has already been taken
- Revocation may impact the ability to coordinate care or continue certain services

## XI. ACKNOWLEDGMENT AND SIGNATURE

I acknowledge that:

- I have read and understand this document in its entirety
- I have had the opportunity to ask questions and receive satisfactory answers
- I understand the structure of services during this transition period
- I voluntarily consent to receive services as described above

Patient Name: ____________________________________________

Patient Signature: _________________________________________

Date: ____________________