Frontier Health and Wellness, LLC (on behalf of its Contracted Providers)

Consent to Treat and Consent to Financial Responsibility

_____ **(Initial) Guarantee of Outcomes**. By initialing here, you recognize that no guarantee of a specific outcome/report has been provided. Payment for services does not guarantee or imply specific results from any services provided. This includes but is not limited to testing scores, treatment plan recommendations, assessments and diagnostic evaluations administered and/or completed by a Frontier Health and Wellness (FHW) contracted provider.

_____ **(Initial) Split Custody/Guardianship**. If a patient is a minor, and legal custody is not split 50/50 between guardians or a patient is over the age of 18 but has a legally appointed guardian FHW WILL REQUIRE A COPY of the custody/guardianship documentation from the court. FHW providers request involvement of both parents/guardians within the limitations of the legal custody/guardianship documentation. Please note, that the default position of any provider is to assume 50/50 legal and physical custody/guardianship unless legal documentation is provided. Disclosure of a patients given custody/guardianship status, if it is anything other than 50/50, or a patient over the age of 18 is their own legal guardian, is the responsibility of the parent/guardian.

By initialing here, you are confirming that:

_____ **(Initial)** You are your own legal guardian or that you are guardian of the patient being referenced here,who is over the age of 18, and have provided FHW with all the appropriate legal documentation confirming your guardianship.

OR

_____ **(Initial)** You share 50/50 legal and medical custody of the patient or legal/medical custody is not equally shared between parents and you have provided FHW with all the appropriate court appointed custody documentation.

___ **(Initial) Assignment of authorization to negotiate on your behalf regarding Insurance Benefits and Payment.** By initialing here, you authorize your health insurance provider(s) to directly pay your FHW Contracted Provider(s) any benefits due under the terms of your health care plan(s), for services rendered by your FHW Contracted Provider(s). You hereby permanently assign, handover and set over to FHW and its Contracted Providers all your rights, title and interest to medical reimbursement, containing, but not restricted to, the right to name a beneficiary, add dependent eligibility and to have an individual policy sustained or allotted in agreement with the terms and reimbursements under any insurance policy, compensation certificate or other health benefit indemnification reimbursement otherwise payable to you for any/all services rendered by FHW Contracted Providers in the interim of the claim for care provided by the FHW Contracted Providers. Such irrevocable allocation and assignment shall be for the recovery on said policy or insurance but shall not be construed to be an obligation of FHW or its Contracted Providers to pursue any such right of reclamation. You authorize any and all of your health insurance provider(s) or tertiary client(s) to directly pay FHW Contracted Providers all reimbursements due for services received.

_____ **(Initial) Assurance of Compensation**. By initialing here, you understand and agree that payment for services rendered by your FHW Contracted Provider(s) is ultimately your financial responsibility and will be paid. You agree (whether signing as a guarantor or as a patient), that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account of your FHW Contracted Provider(s) in accordance with the regular fee scheduled and terms of each of FHW Contracted Providers within 30 days of receiving your statement/invoice. You agree that you have been given the opportunity to review your providers fee schedule(s)/rate(s) for services. You agree that you have had all your questions answered regarding possible charges for services rendered by your FHW Contracted Provider(s) and that you will pay the charges that accrue for said services.

Should your account be referred for collection by an attorney or collection agency, you agree to pay in full, the amount not referred for collection by an attorney or collection agency. You agree to pay all the total amount not paid when within 30 days of receiving your statement/invoice.

If legal custody/guardianship is shared (to included medical treatment costs) FHW and its Contracted Providers will require one parent/guardian to be the primary contact/guarantor for any contact regarding billing purposes.

_____ **(Initial) Medicaid/Denali KidCare/Medicare**. By initialing here, you acknowledge that you have been informed that services rendered at FHW through an FHW Contracted Provider cannot be billed to **Alaska Medicaid, Denali KidCare or Medicare Insurance Plans.** You understand that the financial responsibility for any/all services rendered that is not covered by your commercial medical insurance plan (NOT TO INCLUDE Alaska Medicaid, Denali KidCare or Medicaid) cannot be billed to Alaska Medicaid, Denali KidCare or Medicare. Any/all remaining balances will be your financial responsibility to be paid in full within 30 days of receiving your statement/invoice.

_____ **(Initial) Court/Legal Proceedings.** FHW and its Contracted Providers provide clinical care and do not conduct Forensic or Custody Evaluations. If requested, FHW Contracted Providers will independently choose whether they will take part in requested court proceedings and/or legal matters. By initialing here, you are agreeing that you, nor your representative(s) will subpoena FHW or its Contracted Providers for matters related to personal court proceedings and/or legal cases.

_____ **(Initial) Cancellation Policy and Agreement.** Appointments must be canceled within 2 business days or more to avoid a late cancellation/no show fee. Cancellations can be provided via email to contact@FHWAK.com, or a voicemail message on the FHW voicemail, each of which are time stamped for verification. Accruing 4 or more no-showed appointments/late cancellations within a rolling calendar year may result in termination of the patient/provider relationship. If you no-show or provide a late cancellation two or more initial intake appointments, you may be removed from the FHW Contracted Provider's services/schedule.
The fee for a late cancellation or no-show is decided independently with each FHW Contracted Provider. These fees range from $50.00 to 100% of the appointment cost but for specific charges, please consult your provider directly. Please know that insurance companies do not cover missed appointment fees and the accumulated balance will be your sole financial responsibility.

____ **(Initial) Confirmation Calls.** Confirmation/Reminder calls, emails and or text messages are a courtesy that FHW may provide on behalf of its Contracted Providers. The absence of a confirmation/reminder call, email and/or text does not invalidate the ***Cancellation Policy Agreement.***

_____ **(Initial) Medical Record Requests**. FHW staff will work with our Contracted Providers to manage all incoming medical records requests. Each request will be completed in accordance with State of Alaska Statues which allow a provider 30 days after the valid request is received to complete it.
Record requests from health care facilities, mental health clinics, hospitals, academic centers, and other related institutions will require a completed and signed FHW Release of Information (ROI) to be on file. These releases can be found on the FHW website, or one can be provided to you during your office visit. If you have any questions on how to fill the document out, please contact the FHW front desk. Please note that court orders do not require a release of information from the patient or parent/guardian.

____ **(Initial) Mental Health Emergencies.** If you are ever experiencing a psychiatric/psychological emergency (e.g. harm to self or others), you are instructed to call 911 or, if able, go to The Providence Psychiatric Emergency Room in Anchorage; 3200 Providence Drive Anchorage, AK 99508. FHW or its Contracted Providers do not provide emergency or after hours call services or medical care and will use the above listed resources in the event of any psychiatric/psychological emergency.

_____ **(Initial) Electronic Communication and Phone Contact.** Electronic communication; whether through email or the FHW website; phone calls, refill requests and other associated correspondence with an FHW Contracted Provider are all tasks that require time and resources. Due to this, the above-mentioned correspondence is often a billable service.
Note: Insurance coverage of these types of services is inconsistent and varies by coverage plan. Please check with your insurance company to determine what level of coverage you have regarding these types of electronic, telephonic, remote, and non-face-to-face services.

_____ **(Initial) Frontier Health and Wellness; Contracted Providers.** Frontier Health and Wellness is a medical management company that contracts with clinical care providers. Each physician/clinician that provides treatment at FHW is an independent contractor. Each provider is responsible for their treatment, clinical management, and billing submissions. Since our providers submit their own billings under their own entities, all insurance submissions, Explanation of Benefits, and bills will be under those individual entities. Please consult the FHW provider information page or the FHW website for information on each provider's individual entity. Frontier Health and Wellness is not a medical or clinical provider and all clinical decision making occurs outside of the authority of FHW. Furthermore, all diagnostic and treatment decisions exist between patient and provider and do not in any way involve FHW or its employees.

_____ **(Initial) Informed Consent for Telehealth Services**. You authorize FHW's Contracted Providers to provide treatment and diagnostic assessment via a telehealth platform and that you understand and agree to the following:
The laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies you will be disclosed to researchers or other entities without your consent.

- You have the right to withhold or withdraw your consent to the use of telehealth during your care at any time, without affecting your right to future care or treatment.
- You understand that you have the right to inspect all information obtained during a telehealth interaction and may receive copies of this information.
- You understand that you may still be expected to pick-up a hard copy of my medication prescription if the medication I am being prescribed is mandated by the DEA to be delivered direct to the pharmacy.

_____ **(Initial) Medication(s) and Refill Policy.** If you need a refill on a medication that you have previously been prescribed from your FHW contracted provider they must be must be requested directly through FHW or your provider. FHW contracted providers cannot honor pharmacy requests due to the inconsistency and inaccuracy of patient medication information. To request a refill please visit the refill request page at FHWAK.com. The Refill Request form must be completed IN-FULL for the provider to process it. Refill requests can also be by phone by calling the FHW prescription refill line at 907-222-6606 option 3. Requests can be sent via email, but these are often delayed as necessary pieces of information are not always included.
Refill requests can take up to 3 business days to process (Saturdays, Sundays and holidays are not considered "Business days" when calling in for refills).
It is the responsibility of the patient/guardian to notify their provider of any other newly prescribed medications or treatments when requesting a medication refill. This is for the safety of the patient to try and avoid any medication reactions that may occur.

_____ **(Initial**) **Access to Pharmacy Claim and Medication History.** By initialing you hereby agree to allow FHW staff and its contracted providers to access your pharmacy claim and medication history in real time through SureScripts. You are authorizing your provider OR an authorized agent working on behalf of FHW to view your pharmacy claims and medication history. This will contain prescriptions and claims that have been submitted by other providers that are not affiliated with FHW. You have the right to revoke this consent at any time. Please submit in writing your desire to revoke consent for FHW and its contracted providers to access your pharmacy claims and medication history.

_____ **(Initial) COVID-19 Virus.** You will follow all Federal, CDC, State of Alaska and Municipality of Anchorage guidelines and mandates regarding the containment of the COVID-19 Virus. You understand that FHW and its contracted providers reserve the right to refuse face-to-face services if you or anyone you have been in close contact with has been/is currently ill or is experiencing symptoms of the COVID-19 virus. You understand that if any member of the FHW staff or one of its Contracted Providers is ill or experiencing symptoms of the COVID-19 virus your regularly scheduled face-to face appointment may be moved to a telehealth appointment or cancelled to maintain the health and safety of all patients.

Acknowledgment I have read the above Consent to Treatment and Consent to Financial Responsibility document from Frontier Health and Wellness on behalf of its Contracted Providers. I understand and accept all the terms set forth above. All my questions and concerns have been answered and addressed by Frontier Health and Wellness staff or my provider prior to signing and submitting this document.

_____	_____	_____
Patient Name	Patient Date of Birth	Date

_____	_____
Patient/Guardian Signature	Guardian Name (if applicable)

Frontier Health and Wellness, LLC Contracted Providers

E. David Hjellen D.O. – Frontier Health Services, Child, Adolescent and Adult Psychiatry
Spencer Augustin D.O., – SRA D.O., LLC, Child, Adolescent and Adult Psychiatry
Victoria Swatek MS, LPC, CATP – Beyond Barriers Counseling, Child, Adolescent and Adult Clinical Therapy
Olivia Harris, Psychiatric Mental Health NP – Olivia Harris, LLC, Adult Psychiatry

Frontier Health and Wellness, LLC
Notice of Privacy Practices
Pediatric/Under Guardianship

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This Notice of Privacy Practice describes how Frontier Health and Wellness, and its Contracted Providers may use and disclose your protected health information to carry out treatment, collecting payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

Frontier Health and Wellness (FHW) and its Contracted Providers are committed to protecting the privacy of your personal health information. Federal regulations provide an additional framework for maintaining the privacy of protected health information while providing individuals with notice of Frontier Health and Wellness' and its Contracted Providers legal duties and privacy practices with respect to protected health information.

As a rule, Protected Health Information is kept confidential unless authorization to release it is provided to FHW.

"Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical/mental health or condition and related health care services.

Frontier Health and Wellness and its Contracted Providers must provide all people it serves with written notice of its privacy practices no later than the date of first service delivery, or as soon as possible after emergency treatment. Frontier Health and Wellness and its contracted providers must obtain written acknowledgment that you have received this notice, or written documentation specifying reasons for not obtaining such acknowledgment.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, you may obtain the revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

If you have any questions about this Notice, please contact the administration of Frontier Health and Wellness, LLC at:

3201 C Street Suite 606 Anchorage, Alaska 99503

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

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 say "no" if 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 insurer. We will say "yes" unless a law requires us to share that information.

Obtaining a list of those with whom we've shared information

- You can request a list (accounting) of the times FHW and/or its Contracted Providers shared your health information for six years prior to the date you ask, who we shared it with, and why.

- FHW will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Obtaining a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. FHW will provide you with a paper copy promptly.

Choosing someone to act for you

- If you have granted someone Medical Power of Attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- FHW will make sure the chosen party has medical authority and can act on your behalf before any action is taken.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how FHW and/or its Contracted Providers share your information in the situations described below, please inform us, and we will do our best to follow your instructions.

In these cases, you have both the right and choice to request the following from us:

- 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

We may also share your information when needed to lessen a serious and imminent threat to health or safety. If this were to occur, FHW and its Contracted Providers would try to inform you before disclosing any information to a parent/guardian or State/Federal entity.

Frontier Health and Wellness and its Contracted Providers will keep the information you share with us confidential unless we have your consent to disclose the information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with us during your treatment. In some situations, providers are required by law or by the guidelines of our profession to disclose information regardless of whether we have the client's permission. Some of these situations are listed below.

- You tell a provider you plan to cause serious harm or death to yourself, and the provider believes you have both the intent and ability to carry out this threat in the very near future. Under these circumstances your provider is obligated to take steps to inform a parent/guardian of what has been disclosed and how serious this threat appears to be. The goal is to ensure that you are protected from harming yourself.
- You tell a provider you plan to cause serious harm or death to someone else who can be identified, and the provider believes you have the intent and ability to carry out this threat in the very near future. In this situation, the provider must inform your parent/guardian AND inform the person whom you intend to harm
- You tell a provider you are engaging in behaviors/activities that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, the provider will need to use professional judgment to decide whether a parent/guardian should be informed
- You tell a provider you are being abused - physically, sexually, or emotionally - or that you have been abused in the past. In this situation, the provider is required by law to report the abuse to the Office of Children's Services.

- You are involved in a court case and a request is made for information about your treatment. If this happens, your provider will not disclose information without your consent unless the court directly requires us to do so. Even under these circumstances your provider and FHW and/or its Contracted Providers will do all they can within the law to protect your confidentiality.

Our Uses and Disclosures

How does FHW and/or its Contracted Providers typically use or share your health information?

FHW and/or its Contracted Providers typically use or share your health information in the following ways.

To Treat You:

FHW and/or its Contracted Providers may use your health information and share it with other professionals who are treating you.

Run Our Organization:

FHW and/or its Contracted Providers may use and share your health information to run our clinic, improve your care, and contact you when necessary.

Bill for Services

FHW and/or its Contracted Providers may use and share your health information to bill and get payment from health plans or other entities.

How else can FHW and/or its Contracted Providers use or share your health information?

FHW and/or its Contracted Providers are authorized or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. FHW must meet many legal requirements before we can share your information for these purposes.

Comply with the law

FHW and/or its Contracted Providers may be required to share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal Privacy Law.

Work with a Medical Examiner

FHW and/or its Contracted Providers may be required to share health information with a Coroner, Medical Examiner when an individual dies.

Address workers' compensation, law enforcement, and other government requests

FHW and/or its Contracted Providers may be required to share health information about you:

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

Our Responsibilities

- FHW and/or its Contracted Providers will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- FHW and/or its Contracted Providers are required by law to maintain the privacy and security of your protected health information.
- FHW and/or its Contracted Providers will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- FHW and/or its Contracted Providers must follow the duties and privacy practices described in this notice and give you a copy of it.

Changes to the Terms of this Notice and Acknowledgment of Receipt

FHW 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.

_____ (initial) You consent to the release of my healthcare information to the Contracted Providers and staff at Frontier Health and Wellness (including, but not limited to receptionists, billing contractor [currently Alaska Billing Services], your insurance company, etc.) to a level that is required for that individual or entity to aid in your medical care.

_____ (initial) You understand that you will be informed about situations that could endanger my child. You know this decision to breach confidentiality in these circumstances is up to the provider's professional judgment and may sometimes be made in confidential consultation another provider.

_____ (initial) You understand that my provider will make every effort to inform me prior to making any disclosure to emergency services and/or a federal/state entity such as OCS or APD. You understand that your provider will use professional judgment and follow mandated legal and ethical practices when making the decision to breach your confidentiality, and that the decision is made solely to maintain the your safety and that of the community.

_____ (initial) You have read the Notice of Privacy Practice policy fully and have all questions answered fully prior to signing this document. You have been given adequate time to study the information and find the information to be specific, accurate, and complete.

Acknowledgment of Receipt of the Notice of Privacy Practices

Patient Name (Printed): _____ **Date:**_____

Patient Signature (If 8 or older): _____ **Date:**_____

Parent/Guardian Signature: _____ **Date:**_____

Provider or FHW Representative Signature _____ **Date:**_____

Telephonic Communication and E-Mail Policy
FRONTIER HEALTH AND WELLNESS, LLC
On Behalf of its Contracted Providers

This agreement is written on behalf on Frontier Health and Wellness and its Contracted Providers

As a supplement to your in-office appointments, Frontier Health and Wellness (FHW) and its Contracted Providers may use email, text messaging and phone calls to communicate. Set forth below are policies outlining when and how these communication methods should be utilized to maintain your privacy and to enhance communication as well as a place for you to acknowledge your consent for its use.

E-Mail Use

Please note - FHW and its Contracted Providers do not suggest email be primary method of communication due to the security risks. The preference is for patients to utilize their secured patient portal and or the telephonic communication to reach their providers as this is secure and maintains your confidentiality.

_____ (Initial) **Use of Email Correspondence**. By initialing here you understand that emails to our providers regarding clinical matters should be avoided as they are not secure. If the client chooses to send an email regarding a clinical matter, then the email can be saved for reference during the next appointment. If the client chooses to include a clinical question in their email, then these questions will typically be answered via email, however, it is understood that email communication is not a secure medium and that sending a question through this medium authorizes FHW and/or its Contracted Providers to provide our reply through the same medium (unless a request not to reply is included in the body of that email).

_____ (Initial) **Clinical and Diagnostic Risks of Email Use**. By initialing here you understand that email communication can be easily misinterpreted or misunderstood, that questions cannot be fully answered and answers cannot cover all possible risks or outcomes. If you need to discuss a clinical matter with your provider, please call FHW to discuss your matter over the phone or wait to discuss it during your next appointment.

_____ (Initial) **Privacy Security Risks of Email Use.** By initialing here you understand there are inherent security and privacy risks associated with email. That emails may be: seen by unintended viewers if addressed incorrectly. Emails are subject to be intercepted by hackers and used to spread computer viruses. An email may not be received by either party in a timely manner as it may filtered by junk/spam filters. Email communication can be easily misinterpreted which may create a misunderstanding and potentially have a negative effect on your treatment. Due to the lack of identity confirmation that comes with the use of email, emails could be sent by someone posing as you to access your personal information and/or medical records.

_____ (Initial) **Urgent/Emergent Situations:** By initialing here you understand and agree that emails are NEVER to be used for any urgent/emergent situation.
If you/your child are experiencing
- feelings or intent of self harm,
- feelings or intent to harm others,
- a severe medication reaction,
- any urgent/emergent situation that may compromise the safety and wellbeing of you/your child or those around you,

seek Emergency Services by calling 911 and/or by going to your nearest emergency room.

_____ (Initial) **Access to Information and Medical Records**. By initialing here you understand that email correspondence between the patient/guardian(s) will be accessible by all staff members associated with FHW and its Contracted Providers. Emails are considered clinical documentation and thus are printed and filed, becoming a permanent part of the medical record. This also means that emails are discoverable in litigation and may be used as evidence in court.

Telephonic Communication and E-Mail Policy
FRONTIER HEALTH AND WELLNESS, LLC
On Behalf of its Contracted Providers

Appointment Reminders

FHW provides 3 options for appointment reminders: Text Messaging. Phone Calls and/or Emails. You have the right as a patient to decline these types of contact if you choose.

Please initial next to your preferred method of contact?

_____ (Initial)Phone Call _____ (Initial)Email _____ (Initial) Text

By initialing one of the options above you authorize FHW and/or its Contracted Providers to send a text message, email or make a phone call as an appointment reminder to you on the contact number you have provided. By accepting these terms, you agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from my cell phone provider may apply. You understand that appointment related reminders are provided as a courtesy (see Consent to Treat and Financial Responsibility form for details).

_____ (Initial) **Text Messaging**. Due to text messages being an impersonal and insecure mode of communication, FHW and its contracted providers do not text for treatment related messages nor do we respond to text messages from patients/guardians. You are agree that you will not text message FHW staff or any of its Contracted Providers.

_____ (Initial) **Confidential Voicemail.** By initialing here you are authorizing FHW and/or its contracted providers to leave confidential information via voicemail regarding you/your child to include but not limited to: scheduling changes, lab information, prescription/refill information, referral information etc.

Online Management

_____ (Initial) **Social Media.** FHW and its Contracted Providers do not communicate with, or contact, any clients through social media platforms, such as Twitter, Instagram and/or Facebook. These types of social contacts can create significant security risks for you and your provider. Any communications with clients online have a high potential to compromise the professional relationship as well as your protected health information. Please do not try to contact FHW staff or its Contracted Providers via social media platforms, it will not be responded to.

_____ (Initial) **Web Searches.** FHW and its Contracted Providers will not use social media web searches to gather information about you/your child (unless you specifically ask us to). FHW is aware that others may choose to gather information about FHW or its Contracted Providers in this manner. If you encounter any confusing or disconcerting information about Contracted Providers or other staff at FHW through web searches, please feel free to discuss this with your provider or FHW administration so that we can address your concerns and avoid any potential impact on treatment.

_____ (Initial) **Reviews**. Although it is commonplace to review business' and/or service providers on various websites, if reviews are written regarding FHW or its Contracted Providers they unfortunately will not be responded to. Mental Health Professionals are legally and ethically bound by privacy laws to maintain the confidentiality of all patients which means not identifying patients by responding to comments/reviews posted online. If you encounter any comments/reviews regarding FHW and/or its Contracted Providers that is confusing or disconcerting, please feel free to discuss this with your provider or FHW administration so that we can address your concerns and avoid any potential impact on treatment. We ask that you please do not comment/review FHW and/or its Contracted Providers while in treatment as this may damage the therapeutic relationship or our ability to provide treatment.

Billing

_____ (Initial) **Fees for Services.** By initialing here you understand and there is a billing protocol in place for email and phone call communication. It is understood that email does not allow for the degree of precision and effective communication that face-to-face encounters do. **Emails, phone calls, refill requests and associated correspondence are all tasks that require time and resources, as such, they are often billable services.** Insurance coverage of these types of services is inconsistent. Please check with your insurance company to determine what level of coverage you have regarding these types of online, remote, and non-face-to-face services.

Acknowledgment

_____ (Initial) **The Right to Revoke Consent:** You understand that at any time you have the right to revoke consent for any of the communication methods chosen for patient reminders. You also have the right to revoke consent for FHW and its contracted providers to use email as a method of communication which may or may not have confidential clinical information regarding your care. Your decision to utilize email is strictly voluntary.

I have read the above Telephonic Communications and E-Mail Policy document from Frontier Health and Wellness. I understand and accept all the terms set forth above. All of my questions and concerns have been answered and addressed by Frontier Health and Wellness or my provider prior to signing and submitting this document.

By signing below, I consent to the use of email communication between myself and contracted providers/staff at Frontier Health and Wellness (FHW). I recognize that there are risks to its use, and despite FHW's and its contracted providers best efforts, they cannot guarantee confidentiality. I understand and accept those risks and the policies for email use outlined in this form. I further agree to follow these policies and agree that should I fail do so, FHW and/or its contracted providers may cease to allow me to use email as a means of communication regarding my care/account. I also understand that I may withdraw my consent to communicate via email at any time by notifying FHW or my provider in writing.

_____	_____
Patient Name (Print)	Guardian Name (if applicable)
_____	_____
Patient/Guardian Signature	Date
_____	_____
Authorized E-Mail Address	Authorized Phone Number

Frontier Health and Wellness Contracted Providers

E. David Hjellen D.O. – Frontier Health Services, Child, Adolescent and Adult Psychiatry
Spencer Augustin D.O., – SRA D.O., LLC, Child, Adolescent and Adult Psychiatry
Victoria Swatek MS, LPC, CATP – Beyond Barriers Counseling, Child, Adolescent and Adult Clinical Therapy
Olivia Harris, Psychiatric Mental Health NP – Olivia Harris, LLC, Adult Psychiatry