



Wellness Partners Hawaii, Inc
6700 Kalanianaʻole Hwy Suite 201
Honolulu, HI 96825-1277
Phone: 808-379-6656 | Fax: 808-379-3750
www.wellnesspartnershawaii.com

INFORMED CONSENT

OUR PHILOSOPHY

Wellness Partners Hawaii Inc. ("WPH") works with clients across all Hawaiian Islands. We strive to increase mental health awareness and accessibility throughout the state of Hawaii via the use of technology.

WPH providers are compassionate professionals who work with you in a manner that will put you at ease. WPH will collaborate with you to create an individualized plan that facilitates stability, further growth, and personal development. This plan may include medication management, therapy, and coaching for lifestyle modifications. WPH also offers genetic testing to find the proper medication that could work for you. WPH is committed to working with you to assess your goals, consider the best approaches to meeting them, and continue to find ways to improve yourself, your relationships, your work, and your overall life.

At our mental health clinic, we leverage HIPAA-compliant technology for virtual appointments, efficient patient communication, AI scribe for accurate and timely documentation, and an easy-to-use portal website for patient management that you can access anywhere in the state.

CLIENT SERVICES

Your initial visit with WPH will be in person or over the Internet, with follow-up appointments online and periodic in-person appointments when required. During the first session(s), a WPH Provider will evaluate your current difficulties, previous history, and reason(s) for seeking therapy and psychiatric services. By the end of the evaluation, your WPH provider can offer treatment recommendations, including an initial treatment plan. During this first assessment, you must also consider how comfortable you feel working with your WPH provider. You should discuss any questions about procedures or recommendations with your WPH provider whenever they arise. If you choose not to enter treatment with your WPH provider, our office staff will direct you to your insurance company's list of alternative providers available in your area.

Ordinarily, a provider will conduct an evaluation that spans anywhere from one (1) to three (3) sessions. Sessions usually last 30 - 60 minutes. During this time, you and your WPH provider can mutually decide whether the services provided by WPH will help you meet your treatment objectives. When medication and/or therapy is initiated, sessions are scheduled approximately every one (1) to four (4) weeks at a mutually agreed upon time. However, sometimes sessions may be more or less frequent. Together, you and your WPH provider can decide the frequency of sessions and length of treatment, including whether the therapeutic relationship should continue. For example, reasons to consider terminating the relationship could include: lack of payment, frequent cancellation of appointments, or a client's lack of interest in fully completing therapy.

BILLING AND PAYMENT

It is the practice of Wellness Partners Hawaii Inc. ("WPH") to obtain credit card information from an individual ("Cardholder") to be used for the payment of any fees associated with care provided by WPH to a patient. Cardholder may be someone other than the WPH patient to which this form applies; however, Cardholder should be aware that The Health Insurance Portability and Accountability Act does not permit WPH to disclose protected health information about its patients to Cardholder or any other individual involved in the payment for care without authorization from the WPH patient receiving care.

Private pay patients will be assessed all appointment fees and insured patients will be assessed the balance remaining after insurance processing. Patients will also be assessed tax, as permitted by law and as any applicable insurance plans may allow. A No Show Fee will be assessed for patients who fail to follow WPH's documented No Show Policy.

I authorize WPH to charge my Credit Card indicated below for any balance remaining on my account or the account of the patient if other than Cardholder after each appointment or No Show (per WPH's No Show Policy). I understand that a receipt for each payment will be provided to me via email and the charge will appear on my credit card statement. I further acknowledge that no prior-notification will be provided by WPH before my Credit Card is charged.

I agree to notify WPH in writing of any changes in my Credit Card account information or termination of this authorization. I understand that this authorization will remain in effect until I cancel it in writing. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these transactions on the basis of fraud, so long as the transactions correspond to the terms indicated herein. I understand that by agreeing to these terms, my ability to dispute a charge or question an insurance company's coverage determination will not be compromised.

CANCELLATION AND NO SHOW POLICY

There is a fifty dollar (\$50.00) No Show Fee for appointments missed or cancelled with less than twenty-four (24) hours notice. WPH reserves the right to charge you a No Show Fee when your insurance allows. Please note that insurance companies will not cover No Show Fees and you will be required to pay it before another appointment is scheduled or before prescription refills are authorized. If you miss three (3) scheduled appointments, you will be discharged from the care of WPH and you will need to find another provider to continue your medication management and/or therapy. At the sole discretion of your WPH provider, you may be provided with an amount of medication to last until you can find a new provider; however, any such medication will be for no more than thirty (30) days with no refills.

- Should you miss your initial appointment (the very first one), you will not be allowed to reschedule and will instead need to find another community provider. Not completing required online clinic paperwork prior to your appointment will constitute a No Show, your appointment will be rescheduled, and this will be counted as part of the three missed appointments, as mentioned above.

- If you will be traveling outside the Hawaiian Islands on a scheduled appointment date, you must inform the office of the need to cancel and reschedule. Failure to do so will constitute a No-Show. Your appointment will be cancelled, and this will be counted as one of the three missed appointments, as mentioned above.
- You are responsible for preparing for your telehealth appointment by finding a private, distraction-free location with a stable internet connection. Failure to do so will constitute a No-Show. Your appointment will be cancelled, and this will be counted as one of the three missed appointments, as mentioned above.

MEDICATION POLICY

For the safety of our patients, medication refill requests from pharmacies are generally not accepted. To minimize errors inherent in automated pharmacy refill requests, WPH requires all patients to request prescription refills by contacting the office directly.

- Patients can submit a medication refill request by logging into their account on our Patient Portal and sending a request through secure messaging any time of the night or day. They may also call the office during regular business hours. Patients are responsible for submitting their request for refills at least two (2) weeks prior to running out of their medication. If you use your medication before a refill is due, you must wait for the applicable refill date to set an appointment for more medication.
- Refills beyond what was provided on the original prescription will only be authorized following an appointment with a WPH provider. An original prescription's maximum number of refills will be no more than two (2). Some medications cannot be refilled outside of a scheduled appointment and require a monthly meeting to order a prescription refill.
- A prescription refill will not be granted if your medication is lost or stolen.

You are expected to take your medications as prescribed and not make changes to medication dosing or timing without first talking to your WPH provider. You must notify your WPH provider of ALL medications you take, including medicine prescribed by other providers, over-the-counter drugs, herbals, supplements, and vitamins.

You may be asked to complete urine or blood testing to ensure safe monitoring of treatment.

You must use only one (1) pharmacy for ALL of your medication from ALL of your providers to ensure safe prescription medication management unless there is a reason this is not possible.

WPH is a benzodiazepine (Ativan, Xanax, Valium, etc.) free clinic, and it is our policy not to prescribe them. If you initiate care with WPH, anticipate discussing tapering (discontinuing) this class of medication if prescribed by another provider.

Failure to follow this policy will result in termination as a WPH client.

MEDICATION MANAGEMENT EQUIPMENT POLICY

To participate in WPH's services, you must have access to a scale and blood pressure cuff and are expected to submit vital signs (height, weight, blood pressure, pulse) before every medication management appointment. Failure to provide the requested vital signs before your appointment may delay your ability to receive your prescription/refill.

CLIENT PICTURES AND PHOTO ID

To ensure the accuracy and security of your medical records, as well as to comply with regulatory requirements, we require that you provide a valid photo ID to be copied and placed in our secure electronic medical record. Acceptable forms of identification include a driver's license, state ID card, passport, or other government-issued photo ID.

UNAUTHORIZED RECORDING AND STREAMING PROHIBITED

Recording or streaming any session or other interaction between you and any WPH provider, whether face-to-face or using audio or video communication technology, is strictly prohibited unless prior explicit consent is obtained in writing from all participants. Additionally, the recording or streaming event itself must include the live consent of all participants, with such consent stated at the start of the recording or streaming event or when any additional participant joins a session or interaction already in progress. Violating this general prohibition by covert, unauthorized recording or streaming of any session or interaction will result in dismissal as a WPH patient.

COURT RELATED SERVICES

WPH does not provide or perform evaluations for custody, visitation, divorce or other forensic matters. Therefore, it is understood and agreed that WPH cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings. WPH is not an authorized organization to work with probation, pre-trial services, or CWSB.

MARITAL OR JOINT THERAPY

If you participate in marital or joint therapy, by signing this form you consent for WPH to maintain a single case file for all joint sessions and to release all information contained in the file related to joint sessions upon request by a participant.

CONSENT FOR TELEHEALTH


I understand that a telehealth appointment has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I understand that there are certain limitations with telehealth therapy and therefore acknowledge that I do not consider myself in need of a high level of care, where in office appointments might be better suited. I understand that high level of care includes but is not limited to, actively suicidal, homicidal, delusions, hallucinations, self-harm, and substance abuse and dependence. I understand that my provider has the right to terminate the telehealth relationship and refer me to in office therapy if he/she determines it to be more appropriate.

CLIENT ACKNOWLEDGMENT AND SIGNATURE

I have received a copy of and read WPH's Informed Consent Form, which specifies the general policies that will apply to me as a recipient of services and treatment provided by Wellness Partners Hawaii, Inc. By signing below, I am indicating my consent to treatment.

Patient Name:

Date of Birth:

Patient Signature:  **Date:**

If this form is being completed by a person with legal authority to act on individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

First and Last Name:

Relationship to patient:

Signature:  **Date:**



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COMMUNICATIONS POLICY

EMERGENCY SERVICES

For life threatening emergencies, call 911.

Emergencies are defined as urgent issues requiring immediate action. If you are experiencing a psychiatric or medical emergency and reach the business after hours, call 911 or report to your local emergency room immediately.

For mental health crises, call 988.

The 988 Lifeline is a national network of local crisis centers that provides 24/7, free and confidential support for people in need.

Call or text 988 to access trained crisis counselors who can help people struggling with substance use, considering suicide, mental health crises, or other kinds of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support.

CLIENT/PROVIDER RELATIONSHIP

You and your WPH Provider have a professional relationship that exists exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Provider can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

CONTACTING WPH BY PHONE

You may leave confidential messages for your WPH provider by phone at (808) 379-6656. WPH will make every effort to return phone calls within one (1) business day, with the exception of weekends and holidays.

CONTACTING WPH BY TEXT MESSAGE

Text messaging is reserved solely for administrative matters.

CONTACTING WPH THROUGH THE PATIENT PORTAL

As a WPH client, you have access to an online Patient Portal through our secure electronic medical record system. Consider communicating any non-urgent needs with your WPH provider through the Patient Portal. You may receive a faster response through the Patient Portal than through other means of communication. However, there are limitations to what can be discussed over the Patient Portal. Do not correspond with the Patient Portal regarding emergency or urgent clinical matters.

SOCIAL MEDIA

We do not communicate with or contact any of our clients through social media platforms. We will not send or accept “friend or contact requests” from current or former client’s social networking accounts. In addition, please do not try to contact your WPH Provider/Staff this way. We will not respond and will terminate any online contact, no matter how accidental. We participate on various social networks, but not in a professional capacity. If you have an online presence, there is a possibility that you may encounter your WPH Provider/Staff by accident. If that occurs, please discuss it with your WPH Provider during your appointment. We believe any social media communication with clients has a high potential to compromise the professional relationship, confidentiality, and privacy of the patient and the WPH Provider/Staff.

RISKS OF USING EMAIL/TEXT TO CONTACT WPH

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

1. The privacy and security of email and text communication cannot be guaranteed.
2. Employers, schools, and online services may have a legal right to inspect and keep emails and texts that pass through their systems.
3. Emails and texts can be circulated, forwarded, stored electronically and on paper, intercepted, altered, or used without authorization or detection.
4. Email and text senders can easily misaddress messages, sending information to unintended and unknown recipients.
5. Backup copies of emails and texts may exist even after the sender and/or recipient has deleted their copy.
6. Using email and texts to discuss sensitive information can increase the risk of disclosure to third parties.
7. Emails and texts can introduce viruses into a computer system, potentially causing damage or disruption.
8. Email and texts can be used as evidence in court.

INFORMATION ABOUT THE WAY EMAIL/TEXT MAY BE USED BY WPH

You should be aware that WPH may handle any emails/text messages you send to WPH in the following ways:

1. WPH may print emails/text messages to or from the client concerning diagnosis or treatment and make such emails/text messages part of the client’s medical record.
2. Other individuals authorized to access the medical record, such as WPH staff and billing personnel, will have access to those emails/text messages.
3. Your WPH provider and WPH staff may forward emails/text messages internally to those involved in your care, as may be necessary for diagnosis, treatment, reimbursement, health care operations, and other handling.
4. Your WPH provider and WPH staff will not forward emails/text messages to independent third parties without your prior written consent, except as authorized or required by law.
5. Although your WPH provider and WPH staff will endeavor to read and respond promptly to an email/text message from the client, WPH cannot guarantee that any particular email/text message will be read and responded to within any specific period.
6. WPH will not discuss sensitive medical information, such as details about sexually transmitted diseases, AIDS/HIV, or alcohol/substance abuse over email/text message.

RECOMMENDATIONS FOR USING EMAIL/TEXT TO CONTACT WPH

When communicating by email/text, you should:

- Limit or avoid using an employer’s or other third party’s computer/phone.
- Immediately inform WPH of any changes in your email address or phone number.

For each email to WPH:

1. Include the category of the communication in the email’s subject line for routing purposes (e.g., “prescription renewal”);
2. Include the name of the client in the body of the email; and
3. Review the email to make sure it is clear and that all relevant information is provided before sending.

Acknowledge receipt of emails/texts from WPH when received.

Take precautions to preserve the confidentiality of emails/texts, such as using screen savers and safeguarding computer/phone passwords.

Refrain from using email/text to communicate with WPH regarding sensitive medical information, such as details about sexually transmitted diseases, AIDS/HIV, or alcohol/substance abuse.

Withdraw your Client Consent to Allow Email/Text Correspondence only by email or written communication to a WPH provider or staff.

You should not use email/text for medical emergencies or other time-sensitive matters.

Should you require immediate assistance, or if your condition appears serious or rapidly worsens, you should call WPH's office (for consultation or an appointment) or take other appropriate measures.

Email/text communication is not an appropriate substitute for appointments.



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CLIENT CONSENT TO ALLOW EMAIL/TEXT CORRESPONDENCE

This Client Consent to Allow Email/Text Correspondence Form authorizes Wellness Partners Hawaii Inc. and its providers and staff (all referenced here as "WPH") to communicate with me using open internet email channels. The specific email address that I am currently using is noted below. However, this consent allows WPH to communicate with me using any email address that I provide to WPH and/or any email address through which I send communications to WPH.

By consenting to the use of email by WPH to contact me, I assume the following responsibilities:

1. Informing WPH of any types of information I do not want to be sent by email/text.
2. Following up on emails/texts from WPH and scheduling appointments with WPH when necessary.
3. Following up to determine whether my intended recipient received the email/text and when the recipient will respond, if my email/text requires or invites a response from WPH, and I have not received a response within a reasonable time period.
4. I also acknowledge that open email/text exchanges should generally be limited to communications that do not contain sensitive client information.

I understand that I can opt out of the use of email/text as a means of communication by sending an email to WPH at info@wellnesspartnershawaii.com or by calling 808-379-6656. I understand that some messages already scheduled for delivery may be sent after I opt out, and I authorize WPH up to ten (10) business days to fully process my opt-out request. I understand that WPH is not responsible for information lost due to technical failures associated with my email software or internet service provider.

WPH's Communications Policy, a copy of which has been provided to me, outlines certain risks of using email/text, how WPH will use email/text, and recommendations for using email/text to communicate with WPH.

WPH uses encryption software as a security mechanism when sending email communications. I agree to comply with the use of WPH's encryption software. If I choose not to use encryption software when communicating with WPH, I do so with the full understanding that this increases the risk of violating my privacy.

CLIENT ACKNOWLEDGMENT AND SIGNATURE

I have received a copy of and read (1) this Client Consent to Allow Email/Text Correspondence Form and (2) WPH's Communications Policy and understand the risks of using email/text. I agree and acknowledge that email/text messages exchanged by and between WPH and myself may include protected health information about me. By signing below, I am indicating my consent to the use of email/text by WPH to provide or assist in providing treatment or other services to me.

Patient Name:

Date of Birth:

Patient Signature:

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Date:

If this form is being completed by a person with legal authority to act on individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

First and Last Name:

**Relationship to
patient:**

Signature:

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Date: