LIGHTHOUSE PSYCHIATRY
ADVANCED TMS THERAPY AND RESEARCH
A beacon for recovery and discovery

CONSENT FOR PURPOSE OF INFORMATION, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use and disclosure of my Protected Health Information by Lighthouse Psychiatry for the purpose of diagnosing, providing treatment, obtaining payment for health care bills, or to conduct health care operations of Lighthouse Psychiatry. I understand that the diagnosis or treatment by the Lighthouse Psychiatry providers may be conditioned upon the consent as evidenced by the authorizing signature on this document.

- By initialing and signing this consent form I am agreeing that this Lighthouse Psychiatry clinic can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.
- I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the Lighthouse Psychiatry clinical practice and that the clinical practice is not required to agree to the restriction. However, if Lighthouse Psychiatry agrees to the restriction that I request, the restriction is binding on them. I have the right to revoke this consent, in writing at any time, except to the extent that Lighthouse Psychiatry has taken action in reliance on this consent.
- My "Protected Health Information" means health information, including demographic information, collected from me and created or received by Lighthouse Psychiatry, another heath care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to past, present or future physical or mental health or condition and identifying information, or there is a reasonable basis to believe the information may personally identify the patient named above.
- I understand I have a right to review the Lighthouse Psychiatry Notice of Privacy Practices prior to signing this document. The Lighthouse Psychiatry Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of protected health information that will occur in treatment, payment of bills, or in the performance of healthcare operations of Lighthouse Psychiatry. This notice of Privacy Practices also describes client rights and Lighthouse Psychiatry duties with respect to protected health information.
- Lighthouse Psychiatry reserves the right to change the Privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

CONSENT FOR TREATMENT

General consent: I consent to medical care at this facility. I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care. I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment.

- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.
- I understand that Lighthouse Psychiatry utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations. I understand that my healthcare providers will have access to my healthcare information across the continuum of my care.
- I consent to the release of my prescription history from any pharmacy or drug monitoring agency to my physician or provider.
- I consent to the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
- I consent that this medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

- I understand that if I am deemed danger to myself and/or others, Lighthouse Psychiatry personnel (clinical and non-clinical) can share my medical information to police and/or other appropriate authorities for the protection of myself and/or others potentially at harm.

- I understand that if I am deemed in immediate danger and/or a victim of abuse by an active care giver who lives with me or cares for me consistently, Lighthouse Psychiatry personnel (clinical and non-clinical) can share my medical information to police and/or other appropriate authorities for my protection from the care giver.
    - If I am a child or adolescent, I understand Lighthouse Psychiatry is legally required to report to police and seek immediate help from the police and other protective agencies for my benefit and protection.
    - If I am an adult, I understand Lighthouse Psychiatry requires my explicit consent to report to police my situation. I understand I will need to report to the police to ensure proper protection of my safety.
    - If I am an elderly person, I understand Lighthouse Psychiatry is legally required to report to police and seek immediate help from the police and other protective agencies for my benefit and protection.

- For **TMS therapy**, I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns. I understand an initial psychiatric evaluation appointment is required to determine TMS eligibility. I understand that I may or may not be a candidate for TMS therapy. I understand there is no guarantee the initial psychiatric evaluation appointment will lead to enrollment into our TMS therapy program. I understand if enrolled into the TMS therapy program, there is no guarantee of successful response or remission to treatment. I understand that I will need to sign a separate and more detailed TMS consent form prior to beginning our TMS therapy program.
- For **psychiatric consult service** for evaluation and assessment, I understand that Lighthouse Psychiatry provides only short-term service, which is not to exceed 3 months. I understand an appointment is required with another psychiatrist outside of Lighthouse Psychiatry to allow for smooth transition and coordination of care.
- **I understand Lighthouse Psychiatry is generally a non-medication prescribing clinic, unless otherwise determined by your overseeing Lighthouse psychiatrist for the specific purpose of coordination of care, which will not exceed 3 months.**
- **I understand Lighthouse Psychiatry does not offer long-term medication management. If I'm enrolled in an active maintenance or taper TMS therapy program at Lighthouse Psychiatry, then medication management is potentially available to me on a short-term basis pre-determined by the TMS or medication-prescribing psychiatrist.**
- I understand Lighthouse Psychiatry, on occasion, does participate in research projects and can use my demographical and clinical information for research purposes only. I understand my data used for research will be de-identified and will be combined with other people's data. I understand the research will not interrupt or interfere with my treatment.

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION

Our notice of Privacy Practices provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our use and disclosure form.

IN CASE OF EMERGENCY

Please use the crisis service lines listed below.

- If you are experiencing a life-threatening EMERGENCY, please dial 911!
- Central Arizona **Crisis Line (602) 222-9444**, (800) 631-1314, TTY (800) 327-9254
- National Suicide Prevention Lifeline (800) 273-TALK (8255)
- Veterans Crisis Line, (800) 273-8255, Press 1, www.veteranscrisisline.net/

By signing this document, I agree that photocopies of this document are as legally binding as the original.

I have read and understand and agree to the above terms.

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Patient or Guardian signature Date