DR. JONATHAN TERRY

New Consultation Application

Hello, and thank you for your interest in my consultation and educational practice!

Before we start, I like to make sure we are on the same page. Please use this as an opportunity to ask any questions you may have about my practice to make sure this will be a good fit for you.

Please initial each line below to indicate that you have read, have had a chance to ask questions, and understand and agree with each of these policies:

_____ Psychiatric Risk Questionnaire (Page 2) ____ (Guardian, if applicable)

_____ General Consultation Policies (Page 3) ____ (Guardian, if applicable)

_____ Notice of Privacy Practices (Page 4) ____ (Guardian, if applicable)

_____ Informed Consent for Consultation (Page 5) ____ (Guardian, if applicable)

_____ Financial Disclosure (Page 6) ____ (Guardian, if applicable)

Once this information is submitted and reviewed, I will have an opportunity to respond to you with any questions I have and decide if this consultation model will be a good fit for your health and learning goals. Please note that completion of this application alone is not a guarantee of service, nor does it establish a physician-patient relationship.

Please sign below to indicate your confirmation of this notice as well as your review of the forms contained in this packet:

_____ _____ _____ _____

Printed Name Signature Date signed Date of Birth

_____ _____

Guardian Signature (if applicable) Date signed

DR. JONATHAN TERRY

Psychiatric Risk Questionnaire

Because traditional psychiatrists see patients with a wide range of symptom severity, I like to remind patients that this consultation and education practice is a *low-acuity, consultation model* that may rely on telemedicine and other electronic communications. It may NOT be able to serve the needs of those requiring a higher level of care, more intensive services, after-hours access, and/or in-person services (including detailed physical exam). **No urgent, after-hours, or emergency services are available through this practice.**

Please answer the following questions. You may attach additional papers if needed. If you answer **YES** to any of the following, please contact my office immediately so that we may discuss if my practice would meet your needs or if an alternate provider may be a better fit.

1. Do you currently have any thoughts to hurt or kill yourself or others? ___ No __ Yes
    a. If yes, do you have a plan for how you would do this? _____
    b. If yes, have you taken any steps toward that plan? _____
2. Have you attempted suicide or harmed yourself before? ___ No ___ Yes
    a. If yes, please list the following:
        i. Number of incidents:
        ii. Dates of incidents:
        iii. Method of harm:
        iv. Did you require medical or psychiatric attention:
3. Have you been violent, harmed another person, or received a felony or misdemeanor charge before?

    ___ No ___ Yes
    a. If yes, please list the following:
        i. Number of incidents:
        ii. Dates of incidents:
        iii. Method of harm:
        iv. Did you require medical or psychiatric attention:
4. Have you ever been admitted to a psychiatric hospital, crisis unit, or psychiatric emergency services?

    ____ No ____ Yes
    a. Details:
5. Within the past 5 years, have you used any illicit drug or substance or participated in any form of addiction or drug treatment program? ____ No ____ Yes
    a. Details:

Suicide Contract:

As a patient seeking consultation or education with Dr. Terry, I will keep in my possession a list of names and phone numbers that I will call if I have suicidal thoughts or am in danger of harming myself or someone else. In addition to personal emergency contacts, that list will include 911 (and/or a local emergency number) and 1-800-SUICIDE. Attempts to commit suicide, violence to others, or self-harm may be grounds for termination / transfer of care from this office to a more appropriate level of care. This is for your safety.

_____ _____ _____ _____

Client Name Signature Date signed Date of Birth

_____ _____

Guardian Signature (if applicable) Date signed

DR. JONATHAN TERRY

General Consultation Policies

Dr. Terry's Availability

This consultation and education opportunity is based in the goal of sharing my knowledge and experience in helping people learn and become empowered on their journey toward optimal health. It is not what many may think of as a standard "practice" or "clinic." Services may be requested by adults or by teenagers (14 and up) with parental co-signature of all documents. I pursue this education and consultation practice in addition to other clinical, teaching, and service responsibilities; it is not a full-time endeavor. Because I have no office staff, most communications (secure communications, voicemails, emails, etc.) will be returned within 72 hours. While communication will be returned as promptly as possible, I do not provide any urgent, after-hours, or emergency services. If you are having a medical or psychiatric emergency, do not wait for a call back. Instead, take steps to keep yourself safe; call 911 or go to your nearest emergency room. Also, please note that clients are carefully selected if their needs and goals match those of this practice; receiving education or consultation in this practice does not imply or guarantee my or anyone else's ability to see you in any other setting.

Electronic Communication

A secure messaging service with optional enrollment is provided free of charge to approved clients if requested. While there is more on this in my Privacy Policy, I will summarize here in saying that I cannot guarantee the safety or confidentiality of any third-party electronic communications you elect to use including but not limited to email servers, third-party partners that maintain their own records, (labs, pharmacies, dispensaries, payment services, insurance, etc.), video or telephone services, etc. Appointment reminders are sent by email, but you can opt out if you do not wish to receive them or prefer another method. While email and voicemail are simple and used by many of my clients, I generally will not disclose any Protected Health Information (PHI) electronically without your consent. If you request specific information, this implies your consent for me to respond in the same medium; efforts will be made to encrypt communications and use the Minimum Necessary Standard. You may choose to submit information or ask questions by electronic means at your own risk. Your decision to utilize potentially insecure electronic services implies your consent to whatever privacy and confidentiality standards may be in place for the services you use. Phrased another way, I cannot be responsible for loss or interception of information if your email is hacked, mail is stolen from your mailbox, your computer gets a virus, etc., as this is out of my control.

Scheduling & Termination

Scheduling will be arranged at mutually-available times. Initial consultation may take 1-2 hours. Follow-up visit duration will be scheduled based on recommended services and complexity. Treatment and therapeutic alliance are seen as ongoing and cumulative; if you have not contacted this office in 3 calendar months, it will be assumed that you are no longer interested in follow-up and/or are having your needs met elsewhere. You have the right to terminate your care in this practice with written or verbal notice at any time for any reason. I may also terminate my relationship with you as consultant due to excessive cancelations/missed appointments, your non-disclosure of information, violation of office policies, if you fail to respond to communications, failure to pay for services, symptom acuity beyond what can safely consulted in this setting, symptoms requiring in-person or other consultation, differences in opinion over treatment goals, using non-prescribed, dangerous, or against-medical-advice interventions, or other concerns. **Missed Appointments:** All cancelations require 48 hours. Cancelations or no-shows received less than 48 hours from the time of appointment will be subject to 50% of the fee for the scheduled visit if the appointment time is not filled by another patient.

Standard of Care & Evidence Basis

Some recommendations discussed may not be considered first-line, recommended by the FDA, and/or consistent with the community standard of care. I will inform you any time we deviate from the standard of care or approved indications and inform you of the evidence basis, effects in persons with similar symptoms or history, associated risks, benefits, side effects, and alternatives as well as standard-of-care recommendations.

Medications

Medications will not be prescribed to clients outside the state of California. Controlled or DEA-scheduled medications (Schedule II, III, IV, and V, etc.) are not issued by telemedicine without prior arrangement or in-person consultation. Prescriptions require up-to-date vital signs.

I have reviewed this document, agree with practice policies, and have had an opportunity to ask questions.

_____ _____ _____ _____

Client Name Signature Date signed Date of Birth

_____ _____

Guardian Signature (if applicable) Date signed

DR. JONATHAN TERRY

Notice of Privacy Practices

[Available as zoomable PDF and in larger print upon request]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOUR SIGNATURE BELOW INDICATES YOUR REVIEW, UNDERSTANDING, AND ACCEPTANCE AS WELL AS THE OPPORTUNITY TO ASK QUESTIONS.

This Notice of Privacy Practices describes I, Jonathan Terry, DO, ABIHM, my practice (we), and some related services may use and disclose your protected health information (PHI) to carry out consultation, treatment, payment or business operations, and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical health or condition, treatment, or payment for health care services. This Notice describes your ability to access and control your protected health information. This Notice also describes other information we may collect from you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

You can provide PHI electronically, by mail, and/or during appointments or clinic communications. Your PHI may be used and disclosed to provide health care services to you, to support business operations, to obtain payment for your care, and any other use authorized or required by law. **TREATMENT & PAYMENT:** I will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure the necessary information is accessible to diagnose or treat you. Your PHI will be used, if requested by you, to bill or obtain payment for your health care services. In this agreement, I do not coordinate any third-party coverage of insurance through private insurance or government insurance such as Medicaid or Medicare in this practice. You may at your own discretion disclose information to third party payers to seek reimbursement.

HEALTH CARE OPERATIONS:

I may use or disclose, as needed, your PHI to support the business activities of this office. These activities include, but are not limited to, maintenance of an electronic health record, appointment reminders, quality assessment, employee review, training, licensing/credentialing, to/from Business Associates, and conducting or arranging for other business activities. I may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. Appointment reminders are sent by email, but you may opt out or request another method. I may inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. I may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law; emergency situations; Tarasoff or other reporting laws; public health; health oversight; abuse or neglect; government requirements; legal proceedings; law enforcement; coroners, funeral directors and organ donation; research; criminal activity; military activity and national security; workers' compensation; inmates; and other required uses and disclosures. For minors, your parent or guardian will have open access to your PHI disclosed as permitted under local laws.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, and/or opportunity to object unless permitted or required by law. Without your authorization, this practice is expressly prohibited to use or disclose your PHI for marketing purposes. We may not sell your PHI without your authorization. Your PHI will not be used for fundraising. You may revoke this authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

ACCESS TO AND RESTRICTIONS FOR YOUR PROTECTED HEALTH INFORMATION:

You may inspect and copy your PHI. You may not, however, inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. You may request access to an amendment of your PHI, confidential communications, a restriction on the use or disclosure, or an accounting of disclosures of your protected health information by submitting a written request to this office. You may request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must be in writing and state the specific restriction requested, duration, and to whom you want the restriction to apply. This practice is not required to agree to a restriction that you may request, except if the requested restriction is on a disclosure to a health plan for a payment or health care operations purpose regarding a service that has been paid in full out-of-pocket. You can request to receive confidential communications from this practice by alternative means or at an alternate location. We will comply with all reasonable requests submitted in writing, which specify how or where you wish to receive these communications. This practice may contact you through secure messaging, email, physical (postal) mail, and/or telephone. Please note that no PHI will be offered by potentially unsecure channels (third-party email, voicemail, etc.) without your consent. Your use of these means implies your consent for an appropriate response with the same method, which may include PHI. For example, if you email a question and do not specify otherwise, you agree to receive an email response, which may or may not include PHI using the Minimum Necessary Standard. You can amend your PHI. If we deny your request for amendment, you may file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal. You may request accounting of certain disclosures of your PHI that have been made, paper or electronic, except for certain disclosures which were pursuant to an authorization, for purposes of treatment, payment, healthcare operations (unless the information is maintained in an electronic health record); or for certain other purposes. You may obtain a paper copy of this Notice, upon request.

OTHER INFORMATION COLLECTED:

In addition to protected health information, you may provide other personal information to this practice, third-party payment services (e.g., Paypal) such as your credit card information and bank account information (payment information). Except for any direct payments, this practice denies all liability for any breaches of payment or protected health information offered to a third-party site (e.g., for payment, pharmacy, labs, telemedicine or video conferencing software, third-party medical record servers). You may access, modify and correct this additional information in the same manner as set forth above with respect to protected health information.

REVISIONS TO THIS NOTICE:

This practice and Dr. Terry reserve the right to revise this Notice and to make the revised Notice effective for protected health information and other personal information this practice already has about you as well as any information received in the future. You are entitled to a copy of the Notice currently in effect. Any significant changes to this Notice will be posted or communicated to any active clients.

BREACH OF HEALTH INFORMATION:

I will notify you if a reportable breach of your unsecured protected health information is discovered. Notification will be made to you no later than 60 days from the breach discovery and will include a brief description of how the breach occurred, the PHI involved, and contact information for you to ask questions.

COMPLAINTS:

Complaints about this Notice or questions may be submitted at any time. This practice will maintain the privacy of, and provide individuals with, this Notice of our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. If you have any questions about this Notice, please contact Dr. Terry, identified as the Privacy Officer using the information in the document footer.

_____ _____ _____ _____

Patient Name Signature Date signed Date of Birth

_____ _____

Guardian Signature (if applicable) Date signed

DR. JONATHAN TERRY

Informed Consent for Consultation

1. Collaboration and consultation can result in many benefits; however, working toward these benefits requires active effort on the part of the client toward these goals.

2. Scope of practice in California is limited to low-acuity, outpatient, consultative psychiatry and integrative/functional medicine services, on a case-by-case basis including but not limited to diagnosis, treatment through various modalities, medication management, and laboratory testing. Outside of California, consultation is available for educational, learning, business development, leadership, and coaching purposes only, and no diagnosis or treatment services are offered or implied. I am under no obligation to accept any opinions or suggestions given to me through this service.

3. This practice does not offer primary care, after-hours access, emergency medical services, surgery, inpatient or hospital admission, radiology, or other services that may be considered out of the scope of practice for this low-acuity, consultation-only outpatient and/or telemedicine psychiatry and/or integrative / functional medicine and/or educational / learning practice. I will maintain a separate primary care provider at all times and rely on this provider for my general medical needs and health monitoring.

4. Some suggestions and opinions will closely mirror the community standard of care, while other recommendations may vary. I will be informed of any deviations from the community standard of care or FDA approved indications as well as the evidence basis, risks, benefits, side effects, and alternatives of any proposed or considered suggestion or recommendations. Lab testing may be informative but is generally not diagnostic, and genetic testing is not a guarantee of gene expression. I will pursue my own research prior to consenting to any lab evaluation or treatment. It is my choice whether to engage in any recommended treatments or testing.

5. This practice generally does not issue any controlled or DEA-scheduled medications by telemedicine without prior arrangement or in-person visit. Any prescription medications (available only in CA) will require up-to-date vital signs. No prescriptions or supplements will be refilled beyond 3 months from the last kept visit, though I may choose to pursue ongoing over-the-counter treatments at my own risk. It is my responsibility to adhere to appointments and be mindful of refill times.

6. Dr. Terry does not and cannot make any guarantee of successful treatment, cure, or reduction of symptoms. Payment is due for time and services rendered, without any express guarantee of results of those services. Some recommended services such as the laboratory testing, supplement dispensaries, and pharmacies may offer additional products, services, or upgrades. Dr. Terry cannot assume any liability for services not discussed in visits.

7. My case may be terminated at my discretion or by Dr. Terry for reasons outlined in practice policies.

8. Telemedicine and video conferencing have inherent risks and limitations, and an in-person physician or other health care professional should be regarded as a primary source of information regarding diagnosis and treatment, especially in cases where a physical exam may be necessary or recommended. I have also been advised that I may choose in-person or more local services, which may require my own research and/or referral to another provider. Third-party video or telephone services may be used to offer services, and Dr. Terry will make efforts to prevent but cannot guarantee against interception of data, signal, or confidentiality through third-party internet, telephone, or other providers. Visual observations may also be limited due to technological restraints, lighting, connection speed, hardware, and other variables.

9. I will hold myself to professional standards. I will not partake in dual relationship, verbal abuse, yelling, disrobing of clothing, soliciting the provider, offering gifts/favors, price bargaining/negotiation, partaking in illegal behavior on video camera, manipulating the provider in any way, providing inaccurate information, threatening non-compliance, or other unprofessional behaviors.

10. A government-issued photo-ID (e.g., Driver's License, Passport) will be required at the first visit. With your permission, a screen shot will be taken of you with your photo-ID to help maintain the integrity of your record and access to your health information. I will not take screen shots or record any session without Dr. Terry's written permission.

11. For all visits including telemedicine and in-person, I will be in an environment that allows confidentiality to my satisfaction. I will ensure my own safety during each encounter and not engage in potentially unsafe activities such as driving, operating machinery, or ingestion of mind-altering substances during consultation. If an in-person visit is scheduled outside of the office (for example, a walking visit at a park), Dr. Terry cannot be held liable for any circumstances outside of his control, including but not limited to privacy, safety in transportation, actions of others present, natural disasters, weather, acts of God, etc.

12. As further outlined in the Financial Disclosure, Dr. Terry does not accept government or private insurance or any form of third-party payment in this practice. Dr. Terry does not negotiate with third-party payers on my behalf, nor can he predict what services or products may be covered.

_____ _____ _____ _____

Printed Name Signature Date signed Date of Birth

_____ _____

Guardian Signature (if applicable) Date signed

DR. JONATHAN TERRY

Financial Disclosure

To maximize time and accessibility, Dr. Terry does not bill any insurance plans in this practice, including Medicare and/or Medicaid. If you are a Medicare beneficiary, you may be referred to a practice that processes Medicare claims at your request. Dr. Terry cannot make any guarantee of reimbursement or payment for any insurance plan.

- Services are 100% self-pay and payments are due at the time of service. Payments not received within one week of service may be subject to a late fee or finance charge.
- Services may or may not otherwise be covered by insurance if they were received from a different provider. You have the right to look for in-network providers or providers with alternate insurance arrangements.
- Your insurance is a contract between you and your insurance company, and it is your responsibility to know your benefits and how they may or may not apply.
- There is no guarantee that your insurance company will make any payment on the costs of the services you have purchased. Some fees may be ineligible for any insurance reimbursement. There is no distinction in charges between in-person appointments and those occurring through the use of technology, document review, or correspondence.
- Dr. Terry may recommend lab testing, supplements, and/or prescriptions, which may incur additional fees. For desired services or products, you have the right to "shop around," and are in no way obligated to pursue these services directly through this practice. Services ordered directly through Dr. Terry may include a convenience, cost of doing business, or inventory fee in the price. Fees do not include any optional or non-prescribed add-ons you choose to purchase.
- All active clients will be informed of any updates to the fee schedule at least 30 calendar days in advance of changes and have the right to decline further services and/or be referred to other providers.

Fee Schedule for new consultation for all services EXCEPT SUBOXONE, as of September 1, 2017:

- Initial Assessment, Practice Policy Overview, and Feedback, 60-90 Minutes: **$449**
- Follow-Up Visits for Medication Management AND/OR Psychotherapy AND/OR or Integrative/Functional Medicine, 30-60 Minutes: **$299**
- Medication Management ONLY, 15-30 minutes, **$249**
- Phone calls, emails, letters, forms, prescription renewals, prior authorizations, or document review more than 5 minutes are billed by the quarter-hour at the hourly rate of **$299/hour**
- Missed visits or cancelations within 48 hours of appointment will be charged 50% of appointment fee if the appointment time is not filled by another patient
- Electronic records and secure patient portal access (as available, with no guarantee of service) may be provided free of charge. Printed records may require a nominal fee as determined by acceptable limits at your location.

*My signature below indicates that I choose to collaborate with Dr. Terry on a **self-pay** basis, that I am not a Medicare beneficiary, and that I am 100% financially responsible for full payment on these services. It is my responsibility to inform Dr. Terry if I become a Medicare beneficiary.*

_____	_____	_____	_____
Printed Name	Signature	Date signed	Date of Birth

_____	_____
Guardian Signature (if applicable)	Date signed