COMPLIANCE POLICY

The following is required to fulfill your compliance requirements. Please initial after each statement demonstrating that you read and understand the requirement:

- Attending ALL scheduled appointments. Please notify 24 hours in advance if you are not going to be able to make your appointment. No contact No show will not be tolerated. Payment is due at time of service. _____
- Completing scheduled blood work and urine analysis is required to be scheduled for your follow up appointment with our providers. _____
- Taking all medications as prescribed_____
- The above will be demonstrated by confirmation urine screen. Compliance urines are 100% accurate. Arguing about your results can result in immediate dismissal. _____
- Medication counts. You will need to bring your medication to all of your lab appointments. _____
- Completing all additional requested task. Examples include Cognitive assessments or mental health screening tools. _____

The Following NON-compliance may result in immediate dismissal or tapering/discontinuation of current medication regimen:

- Not taking current medication as prescribed. _____
- Abusing any controlled dangerous substance. _____
- Abusing your current medication regimen. _____
- Taking medication not prescribed to you. _____
- Providing urine that is not your own. _____
- Providing urine that is not the correct temperature. _____
- No call No show. _____
- Rude or argumentative behavior. _____
- ANY threat towards my staff or myself. _____

• Repeated lost or stolen medication. You will only be allowed 1 refill related to this occurrence at our discretion. Your medications are YOUR responsibility. ___

If any compliance requirement is violated you will be required to review and sign a compliance violation log. If you refuse to do this you will be dismissed immediately.

CONSENT TO RELEASE

PSYCHIATRIC / MEDICAL and/or ALCOHOL / DRUG ABUSE

RECORDS

I, _____, BIRTH DATE ____/____/____,

hereby authorize Dustin O. Hayes D.O., Total Eclipse DMH, PLLC to have bilateral exchange of information that is contained in my medical record with:

under the conditions listed below:

• This information will be limited to:

_____Psychiatric/medical/alcohol/drug abuse evaluation.

_____Psychiatric/medical/alcohol/drug abuse discharge summary.

_____Progress notes. ____Psychological testing.

_____Psychotherapy notes. ____Educational testing.

_____Lab studies. ____Other:

_____Medical tests/studies. ____Other:

• Purpose or need for such disclosure: _____Continuing care/ Treatment, and/or _____

_____.

• This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon _____

_____.

(Specific Date, Event or Condition)

- An additional consent must be obtained for any other transfer

or disclosure of this information.

- I understand that I may receive a copy of this release.

CONSENT FOR AUDIO/VIDEO RECORDING

- I give my consent to be AUDIO/VIDEO recorded during any in office or telemedicine appointment.

TOTAL ECLIPSE CONSENT FOR TREATMENT FORM

I am an independently practicing professional. I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are electronically maintained, in accordance with HIPAA and no one else can have access to them without your specific, written permission.

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Total Eclipse DMH. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies via telemedicine or face to face. You will be billed monthly for these services regardless if you use your allotted scheduled time per month.

The undersigned understands that he/she has the right to:

Be informed of and participate in the selection of treatment modalities.

Receive a copy of this consent.

Withdraw this consent at any time.

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this application.

Signature Date

Signature of guardian Date