FRONTIER
PSYCHIATRY

Informed Consent to Treatment

NOTICE TO PATIENT/REPRESENTATIVE: By signing at the bottom of this consent form, you acknowledge that you have read and understood all of the information contained in the following consent document.

SERVICES

I understand that I may have a behavioral health condition that may require treatment. I consent to the proposed evaluation and/or treatment provided at Frontier Psychiatry ("Frontier"). I understand that the services available to me may include but are not limited to:

- evaluation;
- diagnosis;
- treatment planning;
- individual, group, and/or family psychotherapy;
- medication management; and/or
- referral for consultation, second opinion, and/or higher level of care.

I understand how the services are provided. When possible, my behavioral health clinician will discuss other treatment options with me. This could include referrals to other clinicians either within or outside Frontier; substance use disorder treatment; community resources; or other options. I understand that, from time to time, Frontier may need to reassign my care to another clinician.

RISKS AND BENEFITS OF BEHAVIORAL HEALTH TREATMENT

I understand that there are potential risks and benefits of participating in a program for behavioral health treatment.

Benefits may include but are not limited to:

- enhanced quality of life;
- improved functioning;
- reduced psychological distress; and/or
- optimized interpersonal relationships.

Risks may include but are not limited to:

- medication/supplement related side-effects;
- psychological distress related to making life changes and/or psychotherapy content and process;
- effects on interpersonal relationships; and/or
- others' negative perceptions about behavioral health treatment.

There are potential consequences of forgoing behavioral health treatment. These may include but are not limited to:

- persistent and/or worsening psychological distress;
- impaired life satisfaction and/or functioning; and/or
- adverse impact on interpersonal relationships.

PATIENT RIGHTS AND RESPONSIBILITIES

I have been informed of Frontier's Patient Rights and Responsibilities policy and have been offered a copy of them. The Patient Rights and Responsibilities policy is also on the Frontier website at https://www.frontier.care/patientrights. I have reviewed Frontier's Patient Rights and Responsibilities, understand them, and agree to fulfill my Patient Responsibilities.

CONDITIONS OF CONTINUED TREATMENT

I understand that a condition of my continued treatment at Frontier is that I abide by the Patient Responsibilities expectations described in Frontier's Patient Rights and Responsibilities document. I understand that if I demonstrate a pattern of failure to fulfill these Responsibilities, I may be subject to termination from Frontier and termination of my clinician-patient relationship at Frontier.

Patient behaviors that may lead to termination from Frontier and termination of a clinician-patient relationship include but are not limited to:

- abusive, disrespectful, violent, threatening, and/or maladaptive verbal/physical/other patient behavior directed towards Frontier clinicians, staff, and/or other patients;
- failure to regularly attend scheduled visits as evidenced by recurrent Late Arrivals, Late Notice Cancellations, and/or No-Shows;
- failure to adhere to Frontier policy;
- nonpayment and/or failure to meet financial obligations to Frontier;
- display of firearms or weapons;

- inappropriate and/or criminal conduct;
- recurrent failure to adhere to treatment plan/recommendations; and/or
- misuse of prescribed medications (eg, overuse, diversion).

I understand that Frontier will make a good faith effort to provide reasonable advance notice of intent to terminate treatment to allow me to identify an alternative source of behavioral health treatment.

COMMUNICATION WITH FRONTIER

Frontier staff are generally only available during normal weekday business hours, excluding holidays. Your clinicians may work on a part time basis and may only be available to respond to communications on certain days or during certain times. It is important for you and your clinician to discuss their availability and communication expectations at the outset of your treatment relationship and periodically thereafter. Due to schedule constraints, fluctuations in workload, need to dynamically prioritize clinical efforts, and a variety of other factors, there may be a significant delay in clinician response to your telephonic, electronic, and/or other communications.

Frontier, its staff, and your clinician will make a good faith effort to respond to your communications in a reasonable amount of time. However, for any urgent/emergent issues, you should call 911 and/or go to the near emergent/urgent care location (eg, local emergency department). You can also make use of the National Suicide Prevention Lifeline at 1-800- 273-TALK (8255). Please do not use email or other electronic communication methods to communicate any urgent or emergent issues to Frontier as these means of communication may not be confidential and may not be received and answered in a timely manner.

FINANCIAL RESPONSIBILITY

I have been informed of Frontier's Financial Policy and have been offered a copy of them. I have reviewed Frontier's Financial Policy, understand it, and agree to be bound by the terms and conditions described therein.

APPOINTMENT RESCHEDULING, CANCELLATION, AND NO-SHOW POLICY

Definitions:

- No-Show: Failure to present for a scheduled appointment.
- Late Notice Cancellation: Cancellation of an appointment less than forty-eight (48) hours before a scheduled appointment.

- Late Arrival: Arriving for an appointment ten (10) or more minutes after the scheduled start time.
- New Patient: A patient who has not received any professional services from a physician/qualified health care professional at Frontier within the past three (3) years.
- Established Patient: A patient who has received professional services from a physician/qualified health care professional at Frontier within the past three (3) years.

Policy:

- Any requested changes to a scheduled appointment (eg, cancellation, rescheduling) must be made greater than forty-eight (48) hours prior to the scheduled appointment time.
- Late Arrivals:
  - Frontier reserves the right to deny service in the event of a Late Arrival and to require that the appointment be rescheduled to the next available appointment date. Depending on clinician availability, there may be a significant wait time for the next available appointment date.
  - Should a patient have two (2) or more Late Arrivals in a three (3) month period, each subsequent Late Arrival shall be treated as equivalent to a Late Notice Cancellation and shall be subject to the same policies and procedures as Late Notice Cancellations.
- Late Notice Cancellations:
  - The canceled appointment will need to be rescheduled to the next available appointment date. Depending on clinician availability, there may be a significant wait time for the next available appointment date.
  - Should a patient have two (2) or more Late Notice Cancellations (or equivalents) in a six (6) month period, each subsequent Late Notice Cancellation (or equivalent) shall be treated as equivalent to a No-Show and shall be subject to the same policies and procedures as No-Shows.
- No-Shows:
  - No-Show fees are not covered by insurance and patients are personally responsible for paying them.
  - When federal, state, or other regulatory statutes prohibit the assessment of No-Show fees, patients shall not be assessed a fee but shall be subject to all other provisions of the policy including, but not limited to, denial of service and/or termination of the patient-clinician relationship and dismissal from Frontier in the setting of repeated No-Shows. Frontier shall not assess a No-Show fee for Montana Medicaid members in accordance with Montana statutory prohibitions.

New Patient No-Shows:

- Patients shall be assessed a one hundred ($100) dollar No-Show Fee for each New Patient No-Show occurrence.
- Frontier reserves the right to deny services to new patients after they have accrued two (2) or more No-Shows and/or No-Show equivalents.

Established Patient No-Shows:

- First No-Show: Patients shall be assessed a twenty-five ($25) dollar No-Show Fee at the time of their first No-Show.
- Second No-Show: Patients shall be assessed a fifty ($50) dollar No-Show Fee at the time of their second No-Show.
- Three (3) or More No-Shows:
  - For each No-Show occurrence beyond the second, patients shall be assessed a fifty ($50) dollar No-Show Fee per occurrence.
  - Patients may be subject to termination at the discretion of their clinician after accruing three (3) or more No-Shows and/or No-Show equivalents. If a patient's clinician determines that termination is indicated, patients shall receive notice of Frontier's intent to terminate the clinician-patient relationship between the patient and their clinician and to discharge them from Frontier's practice.

BEHAVIORAL HEALTH INTEGRATION, OTHER CARE MANAGEMENT, AND DIAGNOSTIC EVALUATION SERVICES

Frontier leverages behavioral health integration ("BHI"), other care management, and diagnostic evaluation services from time to time to enhance the delivery of behavioral health care to our patients. BHI involves providing additional assessment and monitoring between appointments with your primary psychiatrist or nurse practitioner to determine if there are any opportunities to improve your care. Frontier's team of licensed social workers ("LCSW"), medical assistants, and other clinical staff types collaborate with your primary psychiatrist or nurse practitioner as part of a BHI care team.

When there is a clinical indication for the provision of additional care management and/or diagnostic evaluation services (eg, diagnostic evaluation by an LCSW), certain other care management services may be provided to enhance your behavioral health care. The cost of BHI, other care management, and diagnostic evaluation services are often covered by insurance payors; however, should these services not be covered for any reason, the provision of BHI and/or other care management services may lead to out-of-pocket costs for you.

You have the right to unenroll from BHI and/or other care management services at any time; unenrollment will become effective at the beginning of the month following our receipt of notification of your desire to unenroll. To unenroll from BHI and/or other care management services, please contact Frontier at (406) 200-8471 and/or inform your clinician about your desire to unenroll.

By signing this consent, you consent to Frontier providing BHI, other care management, and/or diagnostic evaluation services to you if you and your clinician decide that any of these services might enhance your care.

REMOTE PATIENT MONITORING SERVICES

Frontier leverages Remote Patient Monitoring services ("RPM") from time to time to enhance the delivery of behavioral health care to our patients. RPM allows our clinicians to monitor physiological parameters (eg, blood pressure, heart rate). The cost of RPM services are often covered by insurance payors; however, should these services not be covered for any reason, the provision of RPM may lead to out-of-pocket costs for you.

You have the right to unenroll from RPM services at any time; unenrollment will become effective at the beginning of the month following our receipt of notification of your desire to unenroll. To unenroll from RPM services, please contact Frontier at (406) 200-8471 and/or inform your clinician about your desire to unenroll.

By signing this consent, you consent to Frontier providing RPM services to you if you and your clinician decide that this service may enhance your care.

GOOD FAITH ESTIMATES

If you are uninsured or not planning to submit a claim to your insurance company for the services provided by Frontier, please contact Frontier at (406) 200-8471 and we will provide you with a Good Faith Estimate of the cost for the anticipated services.

SECURE TELEHEALTH SERVICES

I consent to receive the services described above via telehealth. I understand that Frontier's services are provided exclusively via telehealth. Telehealth involves the use of electronic communications, such as real time audio, video, and data communications, to enable health care clinicians at different locations to share an individual's health information to diagnose, consult, and/or treat the individual. Electronic communications used for telehealth incorporate network and software security protocols to protect the privacy and security of patient health information.

As with any health care service, there are expected benefits and possible risks involving the use of telehealth. The expected benefits associated with the use of telehealth include, without limitation, improved access to health care and the ability to obtain the expertise of clinicians and specialists not readily available in the geographic area. Possible risks associated with telehealth include: potential delays in evaluation or treatment due to technical difficulties with equipment; information being transmitted in insufficient form to allow for a complete medical and/or behavioral health examination by the distant site clinician; information loss during transmission due to technical failures; and, despite security protocols being in place, the privacy of patient protected health information may be compromised when transmitted electronically. By signing this consent, I consent to receive services via telehealth.

SUMMATIVE STATEMENT

I understand my rights, including my right to withdraw my consent in writing at any time to the entirety of this Consent to Treatment or to any of its constituent part(s). I understand that I may request a copy of this Consent to Treatment by contacting Frontier at (406) 200-8471. I can also review Frontier's Consent to Treatment at https://www.frontier.care/treatmentconsent.

I have read and understand all of the information given to me. I have been given enough time to ask questions or get more information and to get answers to my questions. The risks and benefits of the treatment as well as other treatment options have been made clear to me. I have been told what may happen if I do not have treatment. The information provided to me is specific, accurate, and complete. I consent to evaluation and treatment at Frontier.

AUTHORIZING SIGNATURES

Signature of Patient/Representative: _____

Date: _____

If signed by a person other than the patient, print name and state relationship and authority to do so.

Print Name of Representative: _____

Relationship to Patient: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other: