Kaizen Psychiatric Services
14845 SW Murray Scholls Dr, Ste 110 PMB 412
Beaverton, OR - 97007-9237

2025_Communication Policies and Consent to Treat

PRACTICE POLICIES AND CONSENT TO TREAT VIA TELEHEALTH

APPOINTMENTS AND CANCELLATIONS

The standard meeting time for the initial visit is 45-60 minutes and follow up visits are 15-30 minutes. Payment is due within 24 hours of your appointment. You may lose your appointment if payment is not received within 24 hours of your scheduled time. Cancellations and re-scheduled visits will be subject to a full charge if not received at least 24 hours in advance. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for an appointment, you may lose some of the allotted time for that appointment. Your card will be billed 24 hours prior to your appointment.

TELEPHONE ACCESSIBILITY

If you need to contact Kaizen Collective between sessions, please use the patient portal. We are a small practice and often can not answer the phone during patient visits. If you are having trouble logging into telehealth or it is more than 10 minutes after your scheduled appointment time, please text the office ((360) 836-0171).
We are often not immediately available; however, we will attempt to return your call or message within the time frame listed in the Behavior Contract. Please note that Face-to-face video visits are mandatory. Phone (audio only) visits are at the sole discretion of the provider. However, in the event that you are out of town, seriously ill or need additional crisis support, please call 911 or go to your local emergency room.

ELECTRONIC COMMUNICATION

We cannot ensure the confidentiality of any form of communication through electronic media, including, but not limited to, text messages, telephone communication, the Internet, facsimile machines, and e-mail. This is why we require communication via patient portal.

Telemedicine is broadly defined as the use of information technology to deliver medical services and information between two parties that are at different locations. The above electronic means of communication are considered telemedicine. Utilizing telemedicine services through Kaizen Collective is voluntary in nature and you need to understand:

We will protect your protected health information in the same fashion as a brick and mortar practice. However, data breaches can happen, and we cannot assure your information is 100% protected in these circumstances. We will

not use your protected health information for research purposes unless you give us consent to do so. There are potential benefits, risks and subsequent consequences of telemedicine. Potential benefits include, but are not limited to improved access to care, reducing costs, improving the quality of visits, and reduction of travel time associated with medical visits. The medical provider will make assessments, diagnoses, and treatment plans based off all the visual and auditory information provided during the video conference. You must understand that this is limited and posts potential risks including, but not limited to the provider's inability to make complete diagnostic assessments that might require a physical exam and to see the patient in person. During an in-person encounter, a medical provider has the ability to see the entire patient including but not limited to their gait, smell, general appearance, and demeanor. Potential consequences thus include the provider not being aware of clinically significant information that you may not recognize as significant to present verbally to the provider.

MINORS

We require parental consent for all visits, in-person and telemedicine. We require a legal guardian or parent to be present during a portion of the visit to ensure that they are consenting to treatment. Legal Guardians and parents may be legally entitled to some information about a minors treatment. Your provider can discuss what information they can access. For more explanation on this issue, please see the additional information provided by following this link: https://www.kaizenpsychiatric.com/rights-responsibilities

TERMINATION

We can terminate treatment with you at any time. We will not terminate the medical relationship with you without first discussing and exploring the reasons and purpose of terminating. If treatment is terminated for any reason you will need to contact your insurance company for a list of covered providers. You may also choose someone on your own or from another referral source. Please review the 2025 Behavior Contract for a full explanation of expectations as well as what actions will be taken if you are discharged.

CONSENT TO TREAT

I give permission for Kaizen Collective to give me medical/psychiatric treatment.

I allow Kaizen Collective to file for insurance benefits to pay for the care I receive.

I understand that:

I will have to send my medical record information to my insurance company.

I must pay my share of the costs.

I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I have the right to refuse any procedure or treatment.

I have the right to discuss all medical treatments with my clinician.

CONSENT FOR TELEHEALTH CONSULTATION

I understand that I am voluntarily engaging in a telemedicine consultation with Kaizen Collective.

I understand that the video conferencing technology and/or phone consultations will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare 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 my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation that I will be informed of their presence and I will also disclose if there is another individual with me. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will have the right to request the following:

omit specific details of my medical history/physical examination that are personally sensitive to me

ask non-medical personnel to leave the telemedicine examination room: and or

terminate the consultation at any time.

I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with Kaizen Collective to seek out an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation.

I understand that telemedicine has limitations regarding the physical examination. I understand that the physical exam portion of the care provided through Kaizen Collective will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.

Telemedicine services offered through Kaizen Collective are not an Emergency Service and in the event of an emergency or urgent medical issue, I will call 911, go to the emergency department, or go to an urgent care.

To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

CONSENT FOR TELEHEALTH CONSULTATION

By signing this form, I certify:

That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.

That I have had the opportunity to ask questions and have had them answered to my satisfaction.

I do hereby consent and acknowledge my agreement to the terms set forth in the consent to treat via telehealth and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward, and be renewed annually.

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Practice Policies and Consent to Treat

Signed on: * _____

PATIENT SIGNATURE * _____