



Liz Comstock
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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is Protected Health Information?

The term "medical information" is synonymous with the terms "personal health information" and "protected health information" for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable), whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, or others and 2) relates to the past, present, or future physical or mental health or condition of an individual (you); the provision of health care (e.g., mental health) to an individual (you); or the past, present, or future payment for the provision of health care to an individual (you).

Uses and Disclosures of Protected Health Information Without Your Authorization

Federal privacy rules and regulations allow health care providers, including Frontline Mental Health Services, who have a direct treatment relationship with the patient (you) to use or disclose the patient's personal health information, without the patient's written authorization, to carry out the health care provider's own treatment, payment, or health care operations. Frontline Mental Health Services may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization.

Treatment, Payment, or Healthcare Operations: Frontline Mental Health Services will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. We will also disclose protected health information to other providers who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of Frontline Mental Health Services, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by Frontline Mental Health Services or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services Frontline Mental Health Services recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Your protected health information may be used and disclosed by Frontline Mental Health Services and other outside providers who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your provider's practice.



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Frontline Mental Health Services will share your protected health information with third-party “business associates” that perform billing and scheduling services. Whenever an arrangement between Frontline Mental Health Services and a business associate involves the use or disclosure of your protected health information, there will be a written contract that contains terms that will protect the privacy of your protected health information.

Required By Law: Frontline Mental Health Services may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Health Oversight: Frontline Mental Health Services may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Legal Proceedings and Law Enforcement: Frontline Mental Health Services may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process. Frontline Mental Health Services We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice’s premises) and it is likely that a crime has occurred.

Coroners or Funeral Directors: Frontline Mental Health Services may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. Frontline Mental Health Services may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties.

Uses and Disclosures of Protected Health Information With Your Authorization

Disclosure to Family/Friends: Frontline Mental Health Services may provide your health information to a family member, friend, or other person that you consent to as being involved in your care or the payment for your health care. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.



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Your Rights Regarding Protected Health Information

Right to Inspect/Copy Protected Health Information: You have the inspect/obtain a copy of your protected health information. Frontline Mental Health Services will provide a copy of your record within 30 days of receiving a written request. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information.

Right to Request Restrictions of Use/Disclosure: You have the right to request restrictions on certain uses and disclosures of protected health information about you, such as those necessary to carry out treatment, payment, or health care operations. This request must be provided in writing, stating the specific restrictions requested and to whom they apply. Frontline Mental Health Services is not required to agree to your requested restriction.

Right to Choose How You Receive Protected Information: You have the right to request to receive confidential communications from Frontline Mental Health Services by alternative means (specific phone number or email) or at an alternative location. We will accommodate reasonable requests. Frontline Mental Health Services reserves the right to inquire specifically regarding information as to how payment will be handled or specification of an alternative address or other method of contact. Frontline Mental Health Services will not request an explanation from you as to the basis for the request.

Right to Amend Protected Health Information: You may have the right to amend protected health information in my records by making a request to do so in a writing that provides a reason to support the requested amendment. This right to amend is not absolute – Frontline Mental Health Services is permitted to deny the request for specified reasons. You also have the right, subject to limitations, to provide a written addendum with respect to any item or statement in your records that you believe to be incorrect or incomplete and to have the addendum become a part of your record.

Right to Receive a Paper Copy of This Notice: You have the right to receive a paper copy of this Notice at any time, even if previously received electronically.

Right to Receive An Account of All Disclosures: You have the right to receive an accounting of certain disclosures Frontline Mental Health Services has made, if any, of your protected health information. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or healthcare operations, or for which you provided an Authorization. Frontline Mental Health Services will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list provided will include disclosures made in the last six years, unless otherwise specified. Frontline Mental Health Services will provide the list to you at no charge, but if you make more than one request in the same year, you will be charged a reasonable cost based fee for each additional request.



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Right to File a Complaint: You have the right to file a complaint if you feel Frontline Mental Health Services violated your health information privacy rights. Frontline Mental Health Services will not retaliate against you for filing a complaint.

To learn more about your rights under the Health Insurance Portability and Accountability Act (HIPAA), please visit <https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

Changes to the Terms of this Notice

Changes to the terms of this notice can be made at any time and will apply to all protected health information. The revised version will be available on the Frontline Mental Health Services website or by request.

This Notice of Privacy Practices applies to Frontline Mental Health Services and is effective November 21, 2024



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Acknowledgement of Receipt of Frontline Mental Health Services' Privacy Practices:

I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I am aware that the terms of this notice may change at any time and that I can request a revised copy. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

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

Patient Name: _____

Patient Signature _____ Date: _____

Acknowledgement of Receipt of Frontline Mental Health Services' Practice Policies:

By signing this agreement, you agree that you have read Frontline Mental Health Services' Office Policies and you agree to abide by its terms during our professional relationship.

Signature: _____ Date: _____

Print Name: _____



FRONTLINE MENTAL
HEALTH SERVICES
FROM THE FRONTLINE TO PEACE OF MIND

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Consent for Treatment

Having read and understood the above information, I acknowledge that I am seeking outpatient care through Frontline Mental Health Services, and hereby consent to the rendering of such care which may include screening, diagnostic, assessment and therapeutic procedures and such treatment as the practitioner consider necessary. I have the right to consent to, or refuse, any proposed therapeutic course, subject to applicable provisions of law. I will not be involved in any research or experimental procedure without my knowledge or consent. I understand that mental health treatment may involve certain risks and benefits, of which I understand. I also understand the risks and benefits of declining treatment. I am aware that I have the right to request information about alternative treatment options, should they exist.

Patient Name: _____

Patient Signature _____ Date: _____



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Informed Consent for Telehealth

Definition of Telehealth: Telehealth involves the use of electronic communications to enable Frontline Mental Health Services to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information that I have signed also apply to telehealth. Copy of our Office Policies and Therapeutic Informed Consent can be provided.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Frontline Mental Health Services utilizes secure, encrypted HIPAA-compliant audio/video transmission software to deliver telehealth via Doxy.me.
4. Frontline Mental Health Services' advanced practice registered nurse follows the District of Columbia Code § 3-1201.05 for telehealth, as well as the Board of Nursing's regulations and ethical expectations.
5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

Frontline Mental Health Services will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard rates discussed in the office policies would apply. If insurance does not cover telehealth, you can pay out-of-pocket and Frontline Mental Health Services will provide you with a superbill for you to submit to insurance for reimbursement.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician and all my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Patient Name: _____

Patient Signature _____ Date: _____



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Statement of Patient Financial Responsibility

I have read Frontline Mental Health Services' regarding fees, insurance, and payment options for the provision of psychiatric services. I acknowledge that, as the patient, I am personally liable for payment of all treatment and care provided by Frontline Mental Health Services. This applies regardless of whether I have insurance, whether my insurance covers the charges, whether I proceed with treatment, or the success of my treatment, understanding that no guarantees are made. I authorize my insurer to pay any benefits directly to Frontline Mental Health Services, the full and entire amount of bill incurred by me or if applicable, any amount due after payment has been made by my insurance carrier. I have read and accept the terms and conditions of these Patient Financial Responsibility policies and procedures.

Patient Name: _____

Patient Signature _____ Date: _____



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Consent for Release of Confidential Information

Client Name: _____ DOB: _____ Date: _____

I hereby authorize Frontline Mental Health Services to:

Release Information To: Obtain Information From:

Method of Document Delivery: Electronic Oral Written

Individual/Facility/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____ Fax: _____

Relationship to Patient: _____

The following information:

- | | |
|---|--|
| <input type="checkbox"/> All records | <input type="checkbox"/> Laboratory Values |
| <input type="checkbox"/> Progress/Treatment Notes & Plans | <input type="checkbox"/> Other Diagnostic Testing |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Physical Exam Findings |
| <input type="checkbox"/> Medical History | <input type="checkbox"/> Aftercare recommendations |
| <input type="checkbox"/> Psychiatric History | <input type="checkbox"/> Discharge summary |
| <input type="checkbox"/> Medication List | |

Purpose of Release of Information Request: Continuity of Treatment/Coordination of Care

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning psychiatric history, substance use, HIV/AIDS, and/or related conditions.

I understand that I may revoke this authorization at any time upon written notice provided to Frontline Mental Health Services. I acknowledge that such revocation will not be effective if Frontline Mental Health Services has already acted in reliance upon this authorization. This authorization (if not previously revoked) will automatically terminate 365 days after the signature of this form or upon completion of treatment, or at the time of insurance billing, whichever is later.

Prohibition on Re-Disclosure

This information has been disclosed from records protected by Federal Confidentiality Regulations (42 CFR Part 2). The federal rules prohibit making any further disclosure of information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Patient Name: _____

Patient Signature _____ Date: _____