If you are thinking about harming yourself or anyone else, or experiencing any other life-threatening emergency, please STOP filling out this form and call 911 or report to the nearest emergency room immediately.

This office visit is for routine purposes only and cannot support emergency situations.

CONSENTS 2026

Abid Malik, M.D.

Tiffany D. Jones, PA-C, CAQ-PSYCH

Amber Grimm, PA-C

1337 South International Parkway

Suite 1301, Lake Mary, Fl 32746

Telephone: 407-878-0022

Consent of Treatment and Policies

I/we are providing consent for (**patient's name**) _____ to receive services from Burgundy Prime, Inc.'s providers. These services may include psychiatric evaluation, psychotherapy, medication therapy, laboratory tests, diagnostic procedures, and other appropriate therapeutic treatments if deemed necessary by both patient and provider. By signing this consent of treatment, I indicate that consent is given voluntarily and that I am both legally competent and have the authority to provide consent for these services.

I understand that:

- I have the right to be fully informed about or of the nature of the treatment, the risks and benefits, and the available treatment options.
- I have the opportunity to have all questions answered to my satisfaction including the benefits, risks and possible side effects associated with any medication and other available treatment options.
- That this consent of treatment is given voluntarily.
- I have the right to withdraw my consent for this treatment at any time.
- I have the right to receive a copy of this consent at any time.
- No sessions are allowed to be recorded by any type of recording device.
- I have the right to cancel or reschedule my appointment at least 24 hours prior to the scheduled appointment in order to avoid receiving **No Show/Late Cancel fee of $50**

Video Surveillance

To ensure the safety of our patients, visitors and staff Burgundy Prime, Inc. conducts 24-hour audio and video surveillance recordings throughout the premises except for restrooms and provider offices. Access to these recordings is by authorized staff members or law enforcement officials only. Burgundy Prime, Inc. will not use these recordings for promotional purposes but may review intermittently for quality assurance purposes. By entering the premises, you agree to audio/video surveillance.

Discharge Policy

I understand that any disruptive, intimidating, dangerous or illegal activities at this office will be grounds for potential discharge from the practice in accordance with Burgundy Prime, Inc. policy.

Financial Agreement

In consideration of the patient receiving services from Burgundy Prime, Inc., I agree:

- I am responsible for all expenses for treatment. Payment of patient responsibility charges are due at the time of the appointment.
- If Burgundy Prime, Inc. files my insurance for me, I agree to pay for non-covered insurance benefits, co-insurance, co-pays, and deductibles. I understand and agree that regardless of my insurance status I am responsible for the balance on my account for any services rendered. Any failure on my part to provide current information that results in my insurance company subsequently denying payment will be my financial responsibility for unpaid charges.
- I understand I am responsible for payment of **$25 for each document** filled out by Burgundy Prime, Inc. providers.
- There is a charge of **$10 base rate administrative fee for any printed documentation plus $0.10 for each page**. Electronic documentation not printed but uploaded to patient portal will not have a charge associated other than charge associated with filling out documentation.
- A charge of **$50** will be assessed **for each no-show or late cancellation/rescheduled** appointment if less than 24-hours' notice is given.

I authorize Burgundy Prime, Inc. to release any of my medical information, including drug and alcohol and HIV positive test results, to my insurance company(s), as needed to process my insurance claim. I authorize my insurance company to make payments directly to Burgundy Prime, Inc. for covered medical and/or psychological services.

Cancellation/Reschedule/No-Show Policy

This policy has been established to help us serve you better at our office. A **"no-show"** is missing a scheduled appointment. A **"late cancellation/reschedule"** is canceling or rescheduling an appointment within 24 hours of the appointment.

It is necessary for us to make appointments to see our patients as efficiently as possible. No-show and late cancellation/reschedule issues ultimately take away a time slot which can no longer be used for our providers to help other patients. We understand that while patients cannot always make it to their scheduled appointments, we do request that you inform us of any changes at your earliest convenience.

Please note that a $50.00 charge will be assessed for each no-show or late cancellation/rescheduled appointment if less than 24-hours' notice is given.

If you need to cancel or reschedule an appointment, please call the office at (407) 878-0022 to speak with our office staff. This policy is to ensure that all our patients can be seen in a timely manner. Thank you in advance for your cooperation and understanding.

HIPAA Notice of Privacy Practices: As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We 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 a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for 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.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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 protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Telehealth Consent

Definition of Telehealth: Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological healthcare 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. **I understand that I must be physically located within the state of Florida to have a telehealth visit.**
2. I understand privacy and confidentiality laws apply to telehealth, and that no information obtained using telehealth services will be disclosed to researchers or other entities without my written consent.
3. My healthcare provider has explained how the video conferencing technology will be used to conduct a telehealth session, so that unlike a direct patient or provider in person, I will not be in the same room as my health care provider.
4. I understand the potential risks to technology including interruptions, unauthorized access, and technical difficulties. I understand my healthcare provider or I can discontinue the video conference consult or visit if it is believed video conferencing technologies are not adequate for the situation.
5. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of any care at any time, without affecting my right to future care or treatment.
6. I understand that no results for anticipated benefits can be guaranteed or assured by my provider.
7. I understand my healthcare information may be shared with other individuals for purposes of scheduling and billing. Furthermore, I have the right to request to terminate the consultation at any time.
8. I agree certain situations, such as emergencies and crises, are inappropriate for audio, video-, or computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.
9. I consent to receiving text message on my cell phone with Telehealth website link. I understand that text message changes may apply from my cell phone carrier.

BY SIGNINING BELOW I AM INDICATING I AGREE TO ALL OF THE ABOVE CONSENTING INFORMATION SECTIONS. I agree that I have read or had this form read and/or had this form explained to me, that I fully understand its contents including the risks and benefits of the procedure(s), and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

PATIENT NAME: _____ **TODAY'S DATE:** _____

PATIENT SIGNATURE: _____

BURGUNDY PRIME, INC.

1337 South International Parkway, Suite 1301

Lake Mary, FL 32746

www.BurgundyPrime.biz

Phone: (407) 878-0022

Fax: (888)815-1039

CONTROLLED SUBSTANCES AGREEMENT

If you are thinking of harming yourself or anyone else, please STOP filling out this form and call 911 and report to the nearest Emergency Department

BURGUNDY PRIME, INC. PRESCRIBERS: Abid Malik, MD, Tiffany D. Jones, PA-C, CAQ-PSYCH, & Amber Grimm, PA-C

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____

Controlled Substances include many different medications including, but no limited to:

*Stimulants (Adderall, Vyvanse, Concerta, Focalin, Ritalin, etc.)
*Benzodiazepines (Xanax, Klonopin, Ativan, etc.)
*Sleep Aids (Lunesta, Ambien, etc.)

Due to the potential risks associated with controlled substance prescription medications, this agreement will be executed to help prevent misunderstandings and/or potential problems. **By signing below I agree to the following:**

*I agree to engage in treatment at Burgundy Prime, Inc. as recommended by my treatment team. My treatment includes medications, therapy, labs when needed, and any additional services as deemed necessary.

*If Burgundy Prime, Inc. prescribes me a particular controlled substance medication, I will not obtain a prescription for the same controlled substance medication from another prescriber.

*If I see another provider who gives me a controlled substance medication (i.e. a dentist, Emergency Room provider, etc.) I must call the office to inform Burgundy Prime, Inc. prescribers of my medication, dosage, and purpose of the medication. If it is discovered that other providers are prescribing controlled substance medications to me, my Burgundy Prime, Inc. prescribers reserve the right to discontinue prescribing medications and/or discharge me from the clinic.

*Refills for controlled substance medications will be given only during an appointment and during normal business hours. No refills will be given after normal business hours, including evenings and weekends. Burgundy Prime, Inc. requires a 72-hour notice for prescription refill requests. If I

do not return for a medication visit in the requested time period, I understand I may not be able to receive refills.

*I agree to keep scheduled appointments with my Burgundy Prime, Inc. prescribers in order to receive refills. I will not be eligible for a refill if I've not been seen by my Burgundy Prime, Inc. prescribers in the previous 12 weeks.

*I will not use any illegal controlled substances, including heroin, methamphetamine, cocaine, etc. I will not misuse or self-prescribe legal controlled substances. While marijuana is legal in some places for recreational and/or medical use, I will not use marijuana while receiving treatment at Burgundy Prime, Inc without first discussing with Burgundy Prime, Inc. prescribers. If it is discovered that I am using these substances, my Burgundy Prime, Inc. prescribers reserve the right to discontinue prescribing medications and/or discharge me from the clinic.

*I understand that my Burgundy Prime, Inc. prescribers are not responsible for the loss or theft of my controlled substance medication. And, lost or stolen medications will not be replaced. I understand I should report any lost or stolen medications to the police. I agree not to share, sell, or trade my medications. I agree not to take anyone else's medications.

*Prescriptions for most controlled substance medications can only be written for 30-day supply.

*I agree to take my medications as prescribed. I understand that taking extra doses will mean I will be without medication for a period of time. I understand that I cannot obtain an early refill of my controlled substance medication. Controlled substances CANNOT be refilled before the renewal date.

*I agree to complete any labs, urine testing, EKGs, or other testing deemed necessary by my Burgundy Prime, Inc. prescribers. I understand failure to complete these tests, or if my blood or urine shows the presence of other controlled substance medications or illegal substances, my Burgundy Prime, Inc. prescribers reserve the right to discontinue prescribing medications and/or discharge me from the clinic.

*I understand that my prescribers will routinely utilize the Prescription Drug Monitoring Program. I understand that my prescribers will fully cooperate with any law enforcement agency and may give a copy of this Agreement to my insurance company, primary care physician, emergency department, and/or law enforcement agency if needed. I waive any applicable privilege or right of privacy with respect to these authorizations.

*I will only use one pharmacy to obtain my controlled substance medication. I hereby allow my Burgundy Prime, Inc. prescribers to talk with my pharmacist about my medications.

*I have discussed this agreement with Burgundy Prime, Inc. I understand and agree to the rules of this agreement. I understand that if I break any part of this agreement, or if my prescriber decides my controlled substance medication risks outweigh the potential benefit at any point in time, or if my controlled substance medication is no longer necessary, that my controlled substance medication may be stopped.

PATIENT SIGNATURE: _____ **TODAY'S DATE:**_____