CONSENT TO TREAT

Counseling Associates, Mid-South Health Systems, Professional Counseling and Ozark Guidance Center, Inc. are Affiliates of Arisa Health Inc. As such, all consents/agreements are being made between Arisa Health, including its Affiliates, and the individual signing the document.

Condition that warrants treatment:
I have reported to my providers the symptoms and concerns that brought me to treatment. I authorize Arisa Health and Affiliates to provide me with all medically necessary behavioral health services deemed appropriate or advisable by the providers as discussed with me in advance.

Types of treatment:
I understand that the services provided to address my identified needs may include: evaluation by means of interview, psychological testing or psychiatric examining, psychotherapy, counseling, behavior therapy, medication, services by a qualified behavioral health provider and/or other procedures as may be indicated. I understand that these services may be provided face-to-face or through the use of video conferencing - with additional consent.

For certain clinical services, I understand that I may see an advanced practice registered nurse as part of your care. Each advanced practice registered nurse collaborates with one or more of our psychiatrists (a licensed physician) and you may contact them directly about any concerns, complaints or questions.

Medication therapy is just one of many methods used to manage and improve client symptoms. The ability to pull your medication history enables us to review and add current medications prescribed by other doctors to your Active Medication List in our system. Doing so, helps us to provide the best quality care for you and ensures that our medical staff avoid prescribing any medications that will conflict with those you are already taking. Do we have your consent to pull your medication history?

Fees:
I understand that I am personally responsible for the cost of services that I will receive from Arisa Health and its Affiliates and that I may use a third party source to satisfy my bill. In the event I am not eligible for a third party pay source, or the center does not collect from the third party, I understand that I am personally responsible for the cost of these services. Charges may include non-direct time, such as report writing, treatment plan, interpreting tests, etc.

If I have insurance, I authorize payment of insurance benefits to go directly to Arisa Health and its Affiliates., and also the release of the necessary information to proceed with claims.

Benefits and Risks of treatment and alternatives:
I understand the risks and benefits of behavioral health services, including the risks associated with declining a specific service or procedure. Potential risks include but are not limited to: ongoing problems at home/work/school, isolation, possible suicidal ideation, possible legal consequences, etc. Potential benefits include but are not limited to: improved functioning at home/work/school, improved mood, improved stability, increased support, etc. I have been informed of alternative services, such as local support groups, churches, etc. that may be available. I understand that I have the opportunity to participate in the development of a treatment plan and will have the opportunity to discuss treatment recommendations with and ask questions of my providers. I understand that I may refuse treatment recommendations or withdraw from treatment at any time by informing my providers. However, I

understand that there may be additional risks if I choose to withdraw or terminate my care before treatment is complete.

Confidentiality and sharing of information:

A copy of the Notice of Privacy Practices is included in the client handbook. In addition, it is available upon request. It is also posted at each site for ongoing review.

The materials and information obtained during the course of therapy, evaluation, consultation or other mental health services will be treated confidentially, subject to the following limitations: (1) unless you request release in writing; (2) your insurance carrier requests information to assist in payment for services (third-party payers such as Medicaid, PASSE, Insurance, etc.); (3) Circuit Court order is presented; (4) information must be released by mental health professionals in response to legal requirements to report suspected child abuse or abuse of the elderly, suicidal or homicidal intent; (5) as otherwise required by law.

In addition, I understand and consent that any information and/or records or other documents pertaining to my treatment may be shared between and among Arisa Health and its Affiliates for the purposes of my treatment. We only disclose or use your information as set forth in our Notice of Privacy Practices and in accordance with applicable laws protecting the privacy and security of health information. This includes only sharing the minimum necessary based on the individual's need to know. To ensure that all clients receive quality care, clinical staff (psychiatrists, therapists, case managers, etc.) receive supervision on a regular basis and some of your information may be reviewed during such supervision to promote quality care. This information is always handled with the highest professional standards and in accordance with our policies on confidentiality and the protection of patient health information.

In an effort to foster continuity of care, I give my consent to exchange behavioral health information between my Arisa Health Affiliate and my or my child's primary care physician (PCP), while my child and/or I are actively receiving treatment. I also understand that by consenting to the exchange of health information, this will not only apply to my or my child's current PCP, but also any new PCP that is assigned during the course of my or my child's treatment. I further understand that doing so will eliminate the need to resign this agreement every time I or my child changes PCP. The following health information indicated below may be shared with the PCP.

Diagnosis (including drug and/or alcohol information, if applicable), Medications, and Treatment Plan / Recommendations and Any other relevant information that may be needed (this may include drugs/alcohol and/or HIV/AIDS information, when applicable).

Photograph Consent:

I authorize Arisa Health and its Affiliates to photograph me, or my child. I understand the photograph will become part of the medical record and will be observable by the staff of Arisa Health and its Affiliates

ORIENTATION

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Each client is provided a copy of the client handbook upon admission. The following list includes information that is described in detail in the handbook. Clients and/or guardians are provided an opportunity to ask questions related to any of the items prior to signing the orientation form.

- The Mission, vision and person-centered philosophy of Arisa Health and its Affiliates.
- Program and Services Offered
- Days/Hours Services are Available and the 24 hour Crisis Hotline Phone Number
- Building Orientation to Familiarize the client with the premises and emergency exits/procedures
- Program Rules and Expectations/Weapons, Legal and Illegal Medications, Handling of Prescription Medications while in the facility, Alcohol and/or Substance Use, Tobacco
- Outpatient Behavioral Health Definitions/Explanations for Medicaid Clients
- Transition, Discharge criteria and Follow Up Procedures
- Advocacy & Privacy Notice/Confidentiality
- Input from Persons Served/Grievance Procedures
- Advanced Directives
- Non-Violent Practices, our policy related to seclusion/restraint
- Wellness/Universal Precautions/Communicable Diseases/Resources
- Mandated Reporting and how we work with the legal system, if you are court ordered for treatment
- Financial obligations and fees
- Boundaries Policy/Standards of Professional Conduct
- Access to your records

The therapist who completes your assessment is responsible for coordination of your care. If your case is transferred to another therapist, he/she will assume this responsibility and it will be communicated with you

For all clients who receive services through Arkansas Medicaid, the following information is required to be disclosed to you:

- The services to be provided are Outpatient Behavioral Health (OBH) Services and at a minimum the services available to you include: Psychiatric Evaluation and Medication Management, Outpatient Services including individual and family therapy at a minimum and Crisis Services.
- A description of the services and definitions may be requested. Additionally, copies of the Behavioral Health Agency and Outpatient Behavioral Health service rules can be provided upon request.
- A Behavioral Health Agency is a behavioral health provider that can bill Arkansas Medicaid and the PASSEs for services approved by the state. OBH Services eligibility depends on Arkansas Medicaid and Optum Independent Assessment results. SED is a Serious Emotional Disturbance and includes children younger than 18. SMI or Serious Mental Illness includes individuals age 18 and older.
- OBH Services must be medically necessary and you can discontinue services at any time.
- OBHS services may be denied based on a third party payer's (Medicaid/Insurance) policies or rules.
- A wide range of therapeutic services are offered and are based on your agreed upon treatment plan. You may have to pay for services not covered by your payer. We have a sliding fee scale and can educate you about financial assistance options.

- In case of dissatisfaction or grievance, a client may contact an Arisa Health Advocate to resolve the issue at 479-750-2020. You may also contact the Arkansas Medicaid Complaint Hotline at 1-888-987-1200 or 1-800-285-1137 (TTD) or the Division of Provider Services and Quality Assurance at 501-682-2441. You may also call the Department of Health and Human Services at 1-877-696-6775.

In addition to the information that is included in the Client Handbook, the following information will be discussed with you in more detail in your first few sessions with your therapist: the purpose/process of the assessment, clarification of current risks and a plan for managing them, how the treatment plan will be developed and your role in developing and implementing the treatment plan, and the recommended course of treatment.

CLIENT RIGHTS

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By signing this form, the client/parent/guardian is acknowledging that he/she has been offered a copy of the Client Rights, which are also available on the website and posted at the organization and been given an opportunity to ask questions.

TELE-HEALTH CONSENT

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Arisa Health and its Affiliates provide certain health care treatment and services via telehealth in order to provide more timely and efficient care to our clients, when it is medically and ethically appropriate given the client's condition, care setting, and the available technology.

- I understand that I may receive health care services from Arisa Health and its Affiliates through telehealth.
- I understand that 'telehealth' includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.
- I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- I understand that my health care provider(s) or I can discontinue the telehealth consult/visit at any time if my health care provider(s) or I feel that the video conferencing connections or the confidentiality of our discussions are not adequate for the situation.
- I understand that any telehealth consultations or services will not be the same as an in person and face-to-face visit with a health care provider because I will not be in the same room as my health care provider.
- I understand that other Arisa Health associates may be present during the consultation besides my health care provider for technical and billing purposes. All Arisa Health associates will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence at the beginning of the telehealth consult or appointment.

- I understand that I can decline telehealth services at any time without affecting my ability to obtain future care or treatment. If I decline the telehealth services, I understand that Arisa Health and its Affiliates cannot take away any other treatment to which I would otherwise be entitled. If I decline telehealth services, the alternative services available to me, include in person services at available locations, with available health care providers.

Depending upon the scope of services provided, the outcome of the treatment and other factors that may be present during the telehealth service, I understand that my health care provider may request that I see an appropriately trained staff person or employee in-person immediately after the telehealth service if an urgent need arises, including for the health or safety of myself or another individual. I understand that my healthcare information disclosed during the telehealth service may be shared with other individuals as permitted by law for scheduling and billing purposes. The laws that protect the confidentiality of my medical information also apply to health care services and treatment provided via telehealth. As such, I understand that the information disclosed by me during the course of my visit is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and in certain legal proceedings where I make my mental or emotional state an issue.

COMMUNICATION CONSENT

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I consent to receiving communications for scheduling, treatment related issues, paperwork, or other forms that may need to be completed. I understand that these reminders may come directly from Arisa Health and its Affiliates or from a third part vendor under contract by Arisa Health.

I understand that email and text messaging must not be used for urgent or emergency situations. I understand that I must contact 911 or the emergency phone number when immediate response is needed. For non-emergency communications, I understand that I may be contacted for the following purposes: scheduling, rescheduling of appointments, reminders of actions, master treatment plan, master treatment plan review, treatment related issues, paperwork or other online forms that may need to be completed.

Risks of Email or Text Messages used as a method of communication:

- Messages may be sent but not received, or may be delivered to the wrong party.
- Phones or email accounts may be intercepted on both the sending and receiving side, as well as, in transit, which could potentially breach client confidentiality.
- Benefits of Email or Text Messages used as a method of communication:
- Greater availability to send and receive messages to and from Arisa Health and its Affiliates during times and in a manner that is more convenient for you.
- Alternatives: The alternative to digital communication includes personal discussion in sessions, and telephone calls.

I affirm that I understand the following:

- I understand that I am responsible, and not Arisa Health or its Affiliates, for safeguarding my sent and received email, text, phone or video communications in my home or work environment and on shared or public computers if applicable. I understand that a separate password protected account will provide greater security and privacy.
- I understand that email may not be received or may be filtered into a Spam or Junk mail box. To have greater confidence that my email was received, I may request a return-receipt from my email carrier, which acknowledges that the message has been received or delivered.
- I understand that email and text messaging may NOT BE CONFIDENTIAL and should not be used for any sensitive personal or treatment information.
- I understand that email or text messaging is not to be used for any emergency or urgent communications. I agree to follow established emergency contact procedures in the event of a medical emergency.
- understand that email or text message communications based on this consent may or may not become party of my records, as determined by Arisa Health.
- I may revoke this consent for email, text messaging or other digital communication at any time by informing my therapist.
- My therapist may opt to discontinue email or other digital or electronic communication if, in my therapists determination, it is inappropriate or unsafe to continue it. I understand that Arisa Health and its Affiliates have established, and adhere to, confidentiality practices for all client information including communications by phone, email, and text messaging as well as safeguards on the privacy of emails received by employees.
- I understand that email and text messaging are not completely secure and confidential methods of communicating.
- I will promptly notify Arisa Health and its Affiliates of any changes in my email address or phone number for receipt of text messages
- I authorize the communication between Arisa Health and its Affiliates, its health care providers, and me regarding my treatment for the specific purposes set forth above.
- I authorize the automated appointment reminders from the Arisa Health vendor as follows:
- After discharge, I understand that someone may send me a letter or survey or contact me regarding my treatment. I consent to receive this communication.

Record Release Copy Fees

The charges are as follows:

- Client to Self - Email $6.50 (limited to 25Mb)
- Client to Self - Pick Up $6.50 (up to 20 pages, additional fees beyond)
- Client to Personal Representative (person with authority to make medical decisions) Email $6.50 (Limited to 25Mb)
- Client to Others Email $15.00 (Limited to 25Mb)
- Client to Others Fax $15.00 (Maximum 25 pages)
- Client to Others Mail $6.50 (up to 20 pages, additional fees start at page 21) + Shipping Charges

ACCEPTABLE FORMS OF PAYMENT Payable only to Tina Lee, ROI Spec. A.M.R.S. Money Order
Debit/Credit Card (There is a $3.50 charge for the use of debit/credit cards.)

Arisa Family Involvement Consent

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We recognize that children and adolescents are dependent and uniquely situated in a family system; in order to make improvements with behavioral health needs, family involvement is absolutely necessary. This Family Involvement Agreement reviews what you can expect from us and how you can be of help during your child's treatment.

The treatment team agrees to:

1. Support the child and caregiver(s) throughout their time in treatment and in developing a treatment plan that is based on the child's/youth's individual strengths and needs. This plan will include the different types of services that will be provided by the treatment team and the frequency of those services.
2. Provide a therapist and/or other staff members to meet with the child and caregiver(s) to address concerns, behavioral issues, and progress made towards treatment goals. The treatment team may also coordinate and share information with school, family doctor, and other supports to the child, with caregiver permission, to assist the child as a team.
3. Respect the caregivers experience and expertise regarding their child.
4. Provide services to the child and caregiver(s) throughout the year, including during the summer and school breaks services to the child and family throughout the year, including the summer and school breaks.
5. Work with the child and caregiver(s) to decide when treatment is no longer needed and develop supports to assist the child after treatment ends.

The child and family agree to:

1. Fully take part in coming up with a treatment plan involving goals based on the child's and caregiver(s) individual strengths and needs. Part of this plan will also include deciding on how often we need to meet with the treatment team individually and together as a family.
2. Meet with the therapist for Family Therapy as often as decided upon in the treatment plan to address concerns, behavioral issues, and progress made toward treatment goals. These meetings may take place at an Arisa office, at the school, in the home, or by telehealth.
3. If receiving behavioral health care services in a school or TDT setting, meet with the treatment team to develop a plan for services during the summer months and other school breaks.

Barriers to Family Involvement

We understand that there can be barriers to family involvement in treatment. Your therapist will work with you to identify these barriers as well as strategies to overcome them.

I understand that services are voluntary and I can withdraw from services at any time. I understand that this agreement will remain in effect for the duration of services.