LIGHTHOUSE PSYCHIATRY

HIPAA DISCLOSURE, PRACTICE POLICY & PROCEDURE

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices, and/or you may request a revised version by accessing our website.

Your protected health information may be used and disclosed by your provider (physician/clinician/therapist), our office staff and other personnel, directly or indirectly, affiliated with our facility but resides outside of our office 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 physician's practice.

All clients or the client's legal guardian will be provided with a copy of this written policy regarding the clinic's registration procedures, no show/cancellation policy and procedures, billing policies, termination policy, and the client or their legal guardian will accept the terms and conditions by signing an acknowledgment of all clinic practices.

Insurance coverage will be verified as a courtesy for clients who have insurance coverage, prior to the first appointment. If any coverage issues are found during insurance verification, Lighthouse Psychiatry will communicate the information to the client prior to their visit. However, the ultimate responsibility for verifying coverage rests with the client. Benefit information obtained from the insurance company and/or authorization(s) are not a guarantee of payment to Lighthouse Psychiatry. Any charges not paid by the insurance company will be the financial responsibility of the client. Any changes in insurance, deductibles, and/or co-pays are the responsibility of the client. It is not the responsibility of Lighthouse Psychiatry to review the balance of any deductibles, changes in insurance or insurance information, or coordination of benefits. Any charges incurred due to, but not limited to deductibles, loss or change of insurance, or failure to coordinate benefits will be the client's financial responsibility. If authorization for services is required with the client's insurance, Lighthouse Psychiatry will retrieve authorization for the initial services. It is the responsibility of the client to request that Lighthouse Psychiatry obtain additional authorizations after the initial authorization has lapsed and/or all visits authorized have been used. If the client fails to notify Lighthouse Psychiatry or fails to retrieve authorization for the services and authorization is not obtained, any charges incurred that the insurance company denies due to lack of authorization will be the financial responsibility of the client.

FOR **NONSECURE COMMUNICATION:**

- I understand that conventional voicemail, email, text/SMS, and video chat may not be fully secure, and that I have a right to use either secure or nonsecure methods of communication. But, clinic has a right to not receive unsecure communication to protect my HIPAA privacy.
- I agree to inform clinic if I DO NOT allow nonsecure communications.
- I understand the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means.
- I understand that my chosen methods of communication do not affect whether I can receive treatment.
- I also understand that I may terminate this authorization at any time.
- I understand that if I initiate such communication (e.g. by texting or email) that consent for reciprocal communication by clinic is implied.

FOR **FINANCIAL RESPONSIBILITY TO SERVICES AND TREATMENT AT CLINIC:**

- I understand and hereby authorize clinic to charge my credit card or debit my banking account for balances that are over 30 days due, to charge regular office visits at the time of service unless I pay by other means, and to charge for missed appointments according to standard policy as discussed below.
- I understand and agree to have my credit card or banking information will be kept securely on file, and I further agree that, in the event my credit card becomes invalid, I will provide a new valid credit card upon request to be charged for the payment of any outstanding balances owed.
- I understand I may be discharged from clinic services for delinquency of balance for services rendered.
- I understand that I have a right to self-pay for my care and forgo insurance coverage (except Medicare) for personal reasons and/or services are not a covered benefit of my insurance policy. I agree NOT to file out-of-network claims to insurers with whom clinic is an in-network contracted provider. Clinic can provide a 'superbill' to be filed by patients with out-of-network insurers.
- I understand that some specialty, intensive, comprehensive, alternative, experimental, and other services may not be covered by insurance and are offered on a fee-for-service basis due prior to treatment. This will be made clear by clinic prior to provision of service. I understand that clinic will provide a standard receipt on request but not a superbill, and I will not seek insurance reimbursement unless explicitly allowed by my provider.

FOR **NONCOVERED MEDICAID/AHCCCS/MEDICARE SERVICES:**

- I understand not all providers at our facility are designated AHCCCS/Medicaid/Medicare providers and hence appointment availability is limited. Appointment with a noncovered AHCCCS/Medicaid/Medicare provider will not be billed to AHCCCS/Medicaid/Medicare for services rendered. I agree to be financially responsible for all patient responsibility payments not covered by the primary insurance.
- I agree to disclose to clinic if I have AHCCCS/Medicaid/Medicare and, in the event that I don't, I understand that I will be discharged.
- On certain circumstances, the clinic may not be aware I have AHCCCS/Medicaid/Medicare and provides services. I understand such situation is merely an accident and not done so purposefully. I understand clinic will discharge me upon discovery of such information.

I understand that clinic and its providers are NOT obligated to fill out disability and other such paperwork. No disability forms will be filled out for patients in treatment less than 90 days and/or less than 3 encounters. When forms are filled out at the provider's discretion, a per page fee will be assigned to patient or requesting agency/entity/organization. Please note rates and policy subjected to change without notice.

Patient/Legal Representative Signature	Date	Time

FOR **POLICY ON COURT-RELATED SERVICES:**
I understand that clinic and its providers do not work with forensic matters or court-ordered treatment. If subpoenaed to testify or appear in court all related costs and time spent on the matter will be billed to the responsible attorney. Please note rates and policy below subject to change without notice. Court and legal services subject to different and higher rates and restrictions.

Client understands that clinic and its providers do not work with forensic matters or court-ordered treatments.

If subpoenaed to testify or appear in court all related costs and time spent on the matter will be billed to the responsible attorney and client.

Attorney issuing the subpoena will contact the office, **at least 4 weeks in advance of the scheduled court date.** Attorney will need to schedule a defined 4-hour time block for **8:00 am to 12:00 pm** AND/OR **1:00 pm to 5:00 pm**.

STANDBY fees are billed at a flat rate for any part of an hour. "STANDBY" is described as time provider must wait for a telephonic appearance.

APPEARANCE fees are billed at a flat rate for any part of an hour. "APPEARANCE" includes time associated with telephonic testimony and/or physical presence in court/legal office building/building where deposed.

DEPOSITION fees are billed at a flat rare for any part of an hour. "DEPOSITION" includes time outside of court used to gather information as part of the discovery process.

RECORD REVIEW, SUBPOENA WRITTEN RESPONSE, REPORT WRITING fees are billed in blocks of 4-hours at a flat rate per hour. Fees to be paid in advance.

MILEAGE fees are filled at a flat rate for total travel to and from court/deposition/legal office/any other legal location to office address.

SUMMARY OF RATES OF COURT OR LEGAL-RELATED SERVICES ARE AS FOLLOWS:

BILLABLE SERVICES	**Providers with degree in: MD, DO, DNP, NP, PA-C**	**Providers with degree in: PhD, PsyD, LCSW, LPC, LMFT, LMSW, LAC, LAMFT**
CONSULTATION WITH CLIENT/ATTORNEY/ATTORNEY STAFF/LEGAL PERSONNEL	$450 per hour	$250 per hour
COURT TESTIMONY/PHYSICAL APPEARANCE/TELEPHONIC APPEARANCE	$450 per hour	$250 per hour
• STANDBY FEE FOR TELEPHONIC APPEARANCE	$265 per hour	$150 per hour
FEE FOR RECORDS REVIEW, SUBPOENA WRITTEN RESPONSE, REPORT WRITING	$450 per hour (4-hour minimum)	$250 per hour (4-hour minimum)
DEPOSITION FEE	$650 per hour	$450 per hour
MILEAGE FEE	$2 per mile (total travel)	$2 per mile (total travel)
CONCILIATION CONSULTATION (PARENTING ADVISORS, ETC)	*NOT AVAILABLE*	*NOT AVAILABLE*
THERAPEUTIC VISITATION	*NOT AVAILABLE*	*NOT AVAILABLE*

If provider is subpoenaed WITHOUT a four-week notice, Attorney issuing the subpoena will be billed for all appointments that need to be rescheduled.

Attorney issuing the subpoena will be responsible for payment of retainer services in advance and any amount not used will be returned within 15 business days AFTER final judgment in the case.

If court case is continued, the provider's office must be contacted *24-hours in advance* or the attorney issuing the subpoena will be charged for the previously blocked out four-hour period.

Copies of any clinical notes are NOT released without a judge's order. However, if ordered by the court, the provider will provide a written report and case summary with the appropriate signed consents. As listed above, the report writing fee will apply.

FOR DISCLOSURE:
I understand clinic will share my protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of my protected health information, clinic will have a written contract that contains terms that will protect my privacy.

I understand clinic may use or disclose my protected health information, as necessary, to provide me with information about treatment alternatives or other health-related benefits and services that may be of interest to me.

I understand clinic may use or disclose my protected health information in the following situations without my authorization or providing me the opportunity to agree or object. These situations include:

- Clinic may use or disclose my 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. I will be notified, if required by law, of any such uses or disclosures.
- Clinic may disclose my protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Patient/Legal Representative Signature Date Time

- Clinic may disclose my protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- Clinic may disclose my 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.
- Clinic may disclose my protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, clinic may disclose my protected health information if we believe that I have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- Clinic may disclose my protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
- Clinic may disclose my 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.
- Clinic may disclose my 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.
- Clinic may disclose my 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. Clinic 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. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- Consistent with applicable federal and state laws, clinic may disclose my protected health information, if clinic believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Clinic may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- When the appropriate conditions apply, clinic may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- Clinic may disclose my protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.
- Clinic may use or disclose my protected health information if I am an inmate of a correctional facility and my provider created or received my protected health information in the course of providing care to me.

Other uses and disclosures of my protected health information will be made only with my written authorization, unless otherwise permitted or required by law as described below. I may revoke this authorization in writing at any time. If I revoke my authorization, clinic will no longer use or disclose my protected health information for the reasons covered by my written authorization. Please understand that clinic are unable to take back any disclosures already made with my authorization.

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Patient/Legal Representative Signature	Date	Time

CONSENT FOR TREATMENT

I consent to medical care at this facility. I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care. I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment.

- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.
- I understand that Lighthouse Psychiatry utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations. I understand that my healthcare providers will have access to my healthcare information across the continuum of my care.
- I consent to the release of my prescription history from any pharmacy or drug monitoring agency to my physician or provider.
- I consent to the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).
- I consent that this medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- I understand that if I am deemed danger to myself and/or others, Lighthouse Psychiatry personnel (clinical and non-clinical) can share my medical information to police and/or other appropriate authorities for the protection of myself and/or others potentially at harm.
- I understand that if I am deemed in immediate danger and/or a victim of abuse by an active care giver who lives with me or cares for me consistently, Lighthouse Psychiatry personnel (clinical and non-clinical) can share my medical information to police and/or other appropriate authorities for my protection from the care giver.
    - If I am a child or adolescent, I understand Lighthouse Psychiatry is legally required to report to police and seek immediate help from the police and other protective agencies for my benefit and protection.
    - If I am an adult, I understand Lighthouse Psychiatry requires my explicit consent to report to police my situation. I understand I will need to report to the police to ensure proper protection of my safety.
    - If I am an elderly person, I understand Lighthouse Psychiatry is legally required to report to police and seek immediate help from the police and other protective agencies for my benefit and protection.
- I understand the purpose of my treatment session and visit will be thoroughly discussed during my encounter with my provider. The provider will review the benefits, limitations, and potential risks with me during my treatment session and visit.
- I understand I have the right to participate in the treatment decision, development of the treatment plan and expectations, as well as, periodic review and revisions to my treatment plan. I am strongly encouraged to discuss any fears, concerns, or doubts about my progress with my provider, including specific risks and benefits that may be associated with my situation and treatment plan.
- I understand if I disagree with the treatment plan, then I have to right to not continue treatment and session with my provider and volunteer to be discharged from practice.
- I understand there is no guarantee of success and remission of my mental illness from the determined treatment plan.
- I understand if my provider determines I am not compliant to treatment plan and/or treatment plan is not effective to improving my mental illness, I will be discharged from practice.

FOR **TMS THERAPY TREATMENT**:

- I understand the purpose of TMS, a neuromodulation tool using a magnetic coil to stimulate my brain, is used to manage my mental condition, diagnosed by my provider.
- I understand the benefit of TMS is symptomatic improvement of my mental illness.
- I understand the limitations and potential risks of TMS include: no effect, worsening symptoms, suicidal/homicidal ideation, headaches, seizure, and/or scalp discomfort.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.
- I understand an initial psychiatric evaluation appointment is required to determine TMS eligibility. Not all individuals are appropriate for TMS.
- I understand there is no guarantee the initial psychiatric evaluation appointment will lead to enrollment into our TMS therapy program.
- I understand if enrolled into the TMS therapy program, there is no guarantee of successful response or remission to treatment.
- I understand that I will need to sign a separate and more detailed TMS consent form prior to beginning our TMS therapy program.

FOR **PSYCHIATRIC SERVICES** PROVIDED BY LICENSED PROFESSIONALS WITH DESIGNATION OF MD, DO, PMHNP, OR PA-C:

- I understand that Lighthouse Psychiatry provides medication management and TMS treatment.
- I understand I may be prescribed medications that may have both positive and negative effects on my body.
- I understand the benefit of medications is symptomatic improvement of my mental illness.
- I understand the limitations and potential risks of medications include: no effect, worsening symptoms (behavioral, mental, physiological), suicidal/homicidal ideation.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.
- I understand periodic follow up sessions and visits are required and necessary to continue managing my medications.
- I understand that I may not be a candidate for select medications, which my provider will explain during my treatment session and visit.
- I understand there is no guarantee of success and remission of my mental illness from the medications I am prescribed.
- I understand that clinic may request and use my prescription medication history from other providers, state databanks, pharmacies, and/or third-party payers for treatment purposes.
- I understand that clinic and its providers are NOT obligated to dispense medications that they see as potentially harmful, particularly controlled substances such as stimulants (Adderall, Ritalin), benzodiazepines (Xanax, Valium, Klonopin), or narcotic pain-killers. Generally, such prescriptions are not dispensed at the first several meetings, even if they were started by an outside provider; referrals to appropriate detox facilities will be made if indicated. Urine toxicology may be required as a condition of receiving prescriptions for certain addictive and/or controlled medications.

Patient/Legal Representative Signature	Date	Time

- I understand that certain medical conditions can cause psychiatric symptoms, and some psychiatric conditions and medications require laboratory monitoring for safety. Complying with provider orders for laboratory tests (either going to a lab or providing recent results ordered by another provider) is a condition of treatment, and treatment may be terminated for repeated non-adherence.
- I understand it is patient's responsibility to make refill requests at least 7 days before running out of medications.

FOR **PSYCHOTHERAPY (COUNSELING) SERVICES** PROVIDED BY LICENSED PROFESSIONALS WITH DESIGNATION OF MD, DO, PMHNP, PA-C, PHD, PSYD, LCSW, LPC, LMFT, LMSW, LAC, OR LAMFT:

- I understand that Lighthouse Psychiatry provides psychotherapy services.
- I understand psychotherapy is a confidential process designed to help address my concerns, come to a greater understanding of myself, and learn effective personal and interpersonal coping strategies. It involves a relationship between myself and the provider who has the desire and willingness to help me accomplish my individual goals. Psychotherapy involves sharing sensitive, personal, and private information that may at times be distressing.
- I understand the benefit of psychotherapy is symptomatic improvement of my mental illness. Although there are no guaranteed outcomes of psychotherapy, both short and long-term psychotherapy can be beneficial. Potential benefits are usually determined by the type of problem and concerns I present with, as well as, the type of treatment goals identified and degree of motivation and follow through I possess in my treatment. Potential benefits include, but not limited to: 1) improvement in general mood; 2) increase self-esteem and confidence; 3) increase relationship satisfaction; 4) increase ability to manage stress more effectively; 5) increase ability to set and achieve realistic goals; 6) increase ability to manage strong emotional reactions and feelings; 7) increase ability to trust, feel close to, and communicate your feelings, thoughts, and needs more openly to others; 8) increase ability to stop engaging in destructive or ineffective behaviors and replacing them with healthy behaviors; and 9) improvements in decision-making.
- Like all treatment modalities, I understand the inherent limitations and potential risks of psychotherapy. Participating in psychotherapy may involve some discomfort and may evoke strong feelings of sadness, anger, fear, etc. There may be times in which psychotherapy will challenge my perceptions and assumptions or offer different perspectives. The issues presented may result in unintended outcomes, including changes in personal relationships however I should be aware that any decision on the status of my personal relationships is my sole responsibility.
- During the therapeutic process of psychotherapy, I may find that my feeling may worsen before getting better, which is not an uncommon course of events. Personal growth and change may be easy and quick, at times, but may also be slow and frustrating. It is important to carefully evaluate whether these risks are worth the benefits of changing. Potential risks include, but not limited to: 1) lack of improvement or lack of progress towards treatment goals; 2) feelings or symptoms may worsen in the beginning of psychotherapy, which are usually temporary; 3) relationships with others may be impacted; 4) development of feelings for provider due to trusting relationship. However, such provider-patient relationship is never appropriate if it transforms into a social, romantic, emotional, or sexual relationship. If there is development of transference and/or counter-transference feelings that negatively impact a professional therapeutic relationship, then it is the professional duty of the provider to sever that relationship, which includes talking to you about finding another provider and discharging from facility; 5) distress when psychotherapy terminates; 6) worsening symptoms (behavioral, mental, physiological); 7) increased anxiety or depression or confusion; and 8) suicidal/homicidal ideation.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.
- I understand periodic follow up sessions and visits are required and necessary to continue managing my therapeutic progress.
- I understand that I may not be satisfied to the level of my expected therapeutic progress. Hence, I can volunteer to be discharged from clinic.
- I understand that I may not have achieved to the level of progress as deemed by provider and I will be discharged in order to seek a higher level of care necessary for me to achieve the progress I am hoping for.
- I understand there is no guarantee of success and remission of my mental illness from the treatment session and visit.

FOR **REMOTE/VIRTUAL/TELEHEALTH SERVICES**:

- I understand, acknowledge, and agree to the following restrictions:
    - Establish and maintain confidentiality during my electronic communication during session.
    - Maintain privacy of session.
    - The session with provider is privileged and hence, any digital/electronic/video/audio recording of session is strictly prohibited. Breach of privilege will be cause for discharge from provider and/or facility.
    - Provide physical address of current location where session is taking place.
    - Provide my contact information in event of loss communication.
    - In the event of a medical emergency/crisis, I will contact and/or allow contact from crisis intervention team, local police, and/or provider office, to prevent harm to myself and/or others.
    - Confirm my identity at the start of each telehealth session.
    - Conduct telehealth session alone in a space or room free of another person present able to witness or hear session details, unless otherwise requested by provider.
    - Maintain personal responsibility of compliance to treatment plan as established by provider.
    - Telehealth services may be terminated if a) compliance to treatment plan is compromised, b) scheduling becomes problematic, c) excessive NO SHOW to telehealth session, d) not fulfill financial responsibilities or have excessive outstanding balance, and d) display detrimental behavior negatively impacting the overall treatment plan and goal.
    - Telehealth services may change at any time based on changes made by insurance policy. Not all insurance policies are the same. Hence, some may not offer telehealth services. In such case, appointment will be switched to in-person session.
    - Telehealth visits abides to the same NO SHOW/LATE CANCELLATION policy as in-office/in-person visits.
    - Fulfill any financial responsibilities (current or delinquent) prior to entering scheduled telehealth session. Prior to starting my telehealth visit, pay my balance, such as copays, deductibles, coinsurances, and any outstanding balances.
    - Am aware that these responsibilities are subject to change without notice, especially when state and/or federal regulatory agencies or associations update any required compliance policies.
- I understand that in the event of an emergency or crisis, I will contact and/or be contacted by crisis team and/or police.

Patient/Legal Representative Signature	Date	Time

FOR **MINORS TO RECEIVE TREATMENT**:

- I understand that, for minors receiving treatment, decisions about psychiatric, behavioral, and/or medical care must be made by the child's legal guardian(s), who must have an opportunity to be fully informed of the evaluation process and treatment recommendations and options.
- I understand, as legal guardian(s), I must be available and present to communicate with provider at time of treatment session.
- I understand in situation of a parental separation or divorce (except in the case of one parent having sole physical and legal custody), both parents must consent, in writing, to the psychiatric/psychotherapy/behavioral/mental/medical treatment evaluation, and both parents are invited and encouraged to participate in the process of evaluation and treatment. If one parent retains sole physical and legal custody, this parent must provide legal documentation (court order) for the office appointment. Both parents, regardless of custody, have a legal right to medical records. Custody documents are required and must be presented prior first appointment.

FOR **COMPLIANCE TO TREATMENT**:

- To meet treatment goals and expectations, I understand I need to be compliant to: 1) my treatment plan, including, but not limited to, clinical recommendations of my provider, being on-time to my appointments, and being honest about my clinical information; and 2) clinic policies, including, but not limited to, coming all necessary documents and paperwork, signing all consents, and maintaining current on my financial responsibilities.
- I understand that I may be discharged from provider and clinic if I am consistently non-compliant to treatment.

FOR **TERMINATION OF SERVICES**:

- I understand that I may terminate treatment at any time and request that their medical records be sent to another provider.
- I understand that clinic may terminate treatment for reasons including but not limited to: 1) it is determined that inadequate expertise or facilities are available to treat the condition; 2) a higher level of care is required (such as, intensive outpatient, residential, or hospital-based treatment) for safety or acuity; 3) the agreed upon treatment plan is not adhered to due to poor and/or lack of treatment compliance; 4) withholding or misrepresentation of important information; 5) misuse of prescribed medication; 6) multiple no-shows or cancellations; 7) failure to satisfy financial obligation of outstanding balance; 8) gross failure to pay for services rendered; 9) engaging in threatening, obscenity, belligerent, or otherwise disruptive behavior toward providers/staff/company, and/or 10) bringing firearms, vaps/e-cigarettes, weapons, illicit substances, or alcohol onto premise.
- I understand a written notice of termination with a 30-day period with referrals to other community providers is generally offered, except in cases of gross non-adherence, inappropriate, unprofessional, violent, threatening, endangering, and/or abusive behavior that do not allow for any ongoing productive treatment relationship, as well as, pose harmful risk to providers, staff, and/or other patients.
- I understand it is the discretion of the admitting provider, clinical director, medical director, and/or management team, to allow reactivation and re-enrollment into clinic services.

FOR **ACCESS TO MEDICAL RECORDS**:

- I understand that I have the right to inspect and receive copies of my protected health information.
- I understand I may obtain a copy of protected health information about me for so long as clinic maintains the protected health information.
- I understand I may obtain my medical record that contains medical and billing records and any other records that my provider and the practice use for making decisions about me.
- I understand that as permitted by federal or state law, clinic may charge me a reasonable copy fee for copying, printing, producing, collecting, or processing of my medical records.
- I understand that under federal law, however, I 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.
- I understand that depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, I may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.
- I understand I have the right to request a restriction of my protected health information. This means I may ask clinic not to use or disclose any part of my protected health information for the purposes of treatment, payment or health care operations.
- I understand I may also request that any part of my protected health information not be disclosed to family members or friends who may be involved in my care or for notification purposes as described in this Notice of Privacy Practices. I understand my request must state the specific restriction requested and to whom restriction to apply.
- I understand my provider is not required to agree to a restriction that I may request. If my provider does agree to the requested restriction, clinic may not use or disclose my protected health information in violation of that restriction unless it is needed to provide emergency treatment and/or prevent harm to self or others. I understand I am to discuss any restriction I wish to request with my provider.
- I understand I have the right to have my provider amend my protected health information. This means I may request an amendment of protected health information about me in a designated record set for so long as clinic maintain this information. In certain cases, provider may deny my request for an amendment based on provider's clinical judgement and/or presence of risk of harm to self or others.
- I understand I have the right to receive an accounting of certain disclosures provider or clinic have made, if any, of my protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures clinic may have made to me if I authorized clinic to make the disclosure, for a facility directory, to family members or friends involved in my care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. I have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Patient/Legal Representative Signature	Date	Time

FOR **PURPOSE OF EDUCATIONAL TRAINING, STAFF TRAINING, AND RESEARCH DATA COLLECTION AND PUBLICATION**:

- I understand clinic, on occasion, participates in research projects and can use my demographical and clinical information for research purposes only. I understand my data used for research will be de-identified and will be combined with other people's data.
- I understand the research will not interrupt, interfere, or influence my treatment.
- I understand I have the right to be excluded from any research where my identity may be disclosed.
- I understand clinic is affiliated with various academic and educational institutions. Thus, on occasion, there will be non-licensed students and/or licensed in-training professionals in the office who may participate in direct and/or indirect patient care.
- I understand I have the right to refuse participation by these individuals in my session during direct care from my provider. I understand my decision will not interrupt, interfere, or influence my treatment.
- I understand some licensed providers at clinic are under supervision, as part of an ongoing training process. I understand I have the right to refuse treatment from such providers.

IN CASE OF EMERGENCY

I understand Lighthouse Psychiatry and its subsidiary locations DO NOT manage acute crisis and psychiatric emergencies. In addition, all emails and electronic communications are used solely for non-urgent, administrative, and/or marketing purposes only.

In case of emergency, use the crisis service lines listed below.

- If you are experiencing a life-threatening EMERGENCY, please dial 9-1-1
- Central Arizona Crisis Line **(602) 222-9444**, (800) 631-1314, TTY (800) 327-9254
- National Suicide Prevention Lifeline **(800) 273-TALK (8255)**
- Veterans Crisis Line **(800) 273-8255**

Patient/Legal Representative Signature	Date	Time
Legal Representative Name	Relationship	

BEHAVIORAL HEALTH CONTROLLED SUBSTANCE AGREEMENT

Lighthouse Psychiatry is committed to doing all we can to treat your illness. In some cases, controlled substances are used as a therapeutic option in the management of anxiety states, insomnia, attention problems, and chronic pain (may be prescribed elsewhere), which are strictly regulated by both state and federal agencies. This agreement is a tool to prevent misunderstandings about prescription medications and protect both you and the provider by clarifying legal guidelines for proper usage of controlled substances. All patients under facility care must this sign agreement.

I UNDERSTAND, ACKNOWLEDGE, AND AGREE TO FOLLOING STATEMENT LISTED BELOW PRIOR TO RECEIVING TREATMENT.

1. I understand all patients, regardless of treatment plan and modality of treatment, who receive care at Lighthouse, must sign this agreement.
2. I understand that if I am prescribed controlled substances, I will be assessed at risk for abuse or dependence.
3. I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. My doctor will provide treatment to me based upon this Agreement.
4. I understand that if I break this Agreement, my doctor may stop prescribing these medications. In this case, my doctor may taper off the medications over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug dependence program may be recommended.
5. I will not allow anyone else to take, sell, use, or otherwise permit others, including spouse or family members, to have access to any controlled substances that I have been prescribed. The sharing of medications with anyone is forbidden and is against the law.
6. I will safeguard my prescriptions and controlled medications from loss or theft. Lost, stolen, get wet, or destroyed medicines will not be replaced.
7. I understand that my doctor cooperates fully with the Arizona Board of Pharmacy, Controlled Substance Prescription Monitoring Program (AZ CSPMP). My doctor will use information provided by the AZ CSPMP in making decisions regarding my medication choices.
8. I agree I will submit to a blood or urine test, if requested by my doctor, to determine my adherence with my medication and with this agreement.
9. I agree I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
10. All controlled substances must be obtained at the same pharmacy, where possible. Refills will be obtained by written prescription only, during regular office hours.
11. I agree to inform my provider of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
12. I understand it is unlawful to be prescribed the same controlled medication by more than one healthcare provider at a time without each provider's knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a provider, or his/her staff, or knowingly withholding facts from a provider or his/her staff (including failure to inform the provider or his/her staff of all controlled substances that I have been prescribed).
13. I will inform my other healthcare providers of any controlled substances I am taking, and of the existence of this Agreement. In the event of an emergency, I will provide the information about my controlled substances to emergency department providers.
14. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the provider whose signature appears below or, during his/her absence by the covering provider. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.
15. Early refills will not be given. Renewals are based upon keeping scheduled appointments.
16. In the event I am arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given. An in-person follow up appointment is required to assess appropriateness for refill.
17. I understand that these drugs should not be stopped abruptly, because doing so may cause severe withdrawal symptoms.
18. **I understand and acknowledge that I will be discharged from receiving medication management if I compromise any stipulation above.**

All of my questions and concerns regarding treatment have been adequately answered. A copy of this Agreement has been given to me.

I have read, understand, and agree to the terms above. I agree that photocopies of this document are as legally binding as the original copy.

Patient/Legal Representative Signature	Date	Time
Legal Representative Name	Relationship	

LIGHTHOUSE PSYCHIATRY

CONSENT FOR TREATMENT OF MINOR

GENERAL CONSENT FOR TREATMENT OF PATIENT WHO IS A MINOR, AGE OF 17 YEARS AND YOUNGER, AND UNDER CARE OF AN ADULT PARENT/GUARDIAN.

PLEASE SELECTION ONE OPTION BELOW (Put an "X" to the option that applies to you):

	Patient is a minor whose **MARRIED PARENTS HAVE JOINT CUSTODY** in matters of medical treatment. • **EITHER PARENTS** may sign this consent. It is the accompanying parent's responsibility to communicate treatment changes, decisions for care, and medication changes with non-attending parent.
	Patient is a minor whose **DIVORCED/SEPARATED PARENTS HAVE JOINT CUSTODY** in matters of medical treatment. • **BOTH PARENTS** must sign this consent. It is the accompanying parent's responsibility to communicate treatment changes, decisions for care, and medication changes with non-attending parent. • Without exception, MUST provide copy of most current court custody order 24-hours prior to appt.
	Patient is a minor whose **DIVORCED/SEPARATED PARENTS HAVE SOLE CUSTODY** in matters of medical treatment AND the non-accompanying parent has NO LEGAL authority in medical decision-making for minor. • **SOLE CUSTODIAL PARENT** must sign this consent. • Without exception, MUST provide copy of most current court custody order 24-hours prior to appt.
	Patient is a minor whose **LEGAL GUARDIAN(S) HAS SOLE CUSTODY** in matters of medical treatment. • **SOLE CUSTODIAL GUARDIAN** must sign this consent. • Without exception, MUST provide copy of most current court custody order 24-hours prior to appt.

By signing this document, ALL PARTIES have read, understand, and agree to the stipulation above. ALL PARTIES agree that photocopies of this document are as legally binding as the original.

PATIENT Name		Date
MOTHER Name	MOTHER Signature	Date
FATHER Name	FATHER Signature	Date
GUARDIAN Name	GUARDIAN Signature	Date

LIGHTHOUSE PSYCHIATRY

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

PATIENT NAME: _____ **DATE OF BIRTH:** _____ (MM/DD/YYYY)

The medical services that are being rendered today may not be covered by your insurance company for one of the following reasons. This does not mean that you cannot receive medical services. By signing this Financial Responsibility Acknowledgement, you acknowledge full responsibility for all cost of services rendered.

1. Services rendered may not be considered eligible for benefits by your health plan.
2. We are unable to verify benefits or confirm eligibility by your health plan due to after hours or insurance card not present.
3. You do not want to or have health insurance and decided to be a self-pay patient.
4. We do not have the required referral or authorization for services rendered today.
5. We are contracted with your primary insurance; however, we are not contracted with your secondary insurance.
6. Services may be considered out of network.
7. Your insurance carrier will determine what services are covered. You may contact your insurance company directly for questions regarding coverage policies.
8. We are not AHCCCS providers. Hence, we do not submit claims to AHCCCS.
9. FINANCIAL AGREEMENT: The undersigned agrees, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to promptly pay the account in accordance with predetermined rates and terms. Should any account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
10. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned assigns and authorizes direct payment to LIGHTHOUSE and affiliate of any insurance benefits otherwise payable to or behalf of the patients for services rendered. It is understood by the undersigned that he/she is financially responsible for charges not paid according to this agreement.
11. HEALTH PLAN (INSURANCE) OBLIGATION: It is the patient's obligation to assure that the patient's health plan has authorized the services to be provided.
12. It is the responsibility of the undersigned to determine if the clinic providers have a contract with patient's health plan, if applicable.
13. Patient authorizes and request that insurance payments be made directly to LIGHTHOUSE when using my health insurance carrier.
14. Any disputes of covered benefits are solely the patient's responsibility to resolve with patient's insurance company.
15. It is patient's responsibility to update LIGHTHOUSE of any changes to patient's insurance information and status, including, but not limited to, policy, ID, carrier, subscriber, address, or any other information.
16. Patient is solely responsible for keeping track of scheduled appointments, scheduling obligations, and fees accrued for missed appointments.
17. NO SHOW/LATE CANCELLATION policy: a $150 FEE for INTAKES and $100 for FOLLOW-UPS. Payment is due by invoice or prior to next rescheduled appointment. Fees are not covered by insurance and are strictly patient responsibility. Late Cancellation is defined as, but limited to, cancellation of appointment under 24-hours from scheduled appointment, after 12pm on a Friday before a scheduled Monday appointment, 15-mintues after a scheduled intake appointment, 8-minutes after a scheduled psychiatric follow up appointment, or 15-minutes after a scheduled therapy appointment. Terms of Late Cancellation is subject to change without notice.
18. Not all fees are covered by insurance, including, but not limited to, medical records, no show/late cancellation fees, and other admin fees.
19. ALL RATES, FEES, COSTS, AND CHARGES ARE SUBJECT TO CHANGE AT ANY TIME WITHOUT NOTICE.
20. ALL PAYMENTS ARE DUE PRIOR TO SERVICES BEING RENDERED AND/OR SCHEDULING OF FUTURE APPOINTMENTS. These payments include, but not limited to, co-pays, deductibles, co-insurance, incurred administrative fees, no show/cancellation fees, court-related fees, attorney-based fees, collection fees, or any other outstanding balances.
21. DEBIT/CREDIT CARD INFORMATION: The undersigned agrees to store his/her debit/credit card information on file for convenient payment of charges accrued. Information to be stored in secure server. Information to be used on today's and future transactions. Information to be stored for one (1) year and will renew at the one-year anniversary, unless otherwise directed to terminate agreement by written order. Information may be removed at any time prior to anniversary by written order. CARD INFORMATION WILL BE STORED SECURELY: (A) IN A SECURE ON-SITE LOCATION, (B) ON A SECURE ELECTRONIC MEDICAL/HEALTH RECORD COMPANY'S SERVER, AND (C) ON A SECURE CREDIT CARD PROCESSING COMPANY'S SERVER. Internal privacy and security manager will routinely surveillance and monitor for breach of security and personal and financial information. Undersigned will be immediately notified of any known breach and/or leak of personal financial information.
22. DEBIT/CREDIT CARD AUTHORIZATION: The undersigned agrees to have debit/credit card charged for all services rendered, administrative fees, delinquent balances, and other fees not covered or not reimbursed by insurance company. Authorization will remain in effect until (a) undersigned no longer an active client of LIGHTHOUSE, and (b) all accrued debt to the company is paid off.

CARD INFORMATION	
[ ] DEBIT CARD [ ] CREDIT CARD	[ ] MASTERCARD [ ] DISCOVER [ ] OTHER: _____ [ ] VISA [ ] AMEX
CARDHOLDER FULL NAME (as shown on card):	
CARD NUMBER:	
EXPIRATION DATE (MM/YYYY):	
SECURITY CODE:	
BILLING ZIP CODE:	

All charges that have been explained to you are based on "Good Faith" estimate.

I understand that my health insurance coverage has certain restrictions and limitations such as authorization requirements, non-covered services, and/or no out-of-network benefits. Since I have chosen to obtain the services rendered today. I agree to be financially responsible for all related charges if they are not covered by my insurance.

I understand my financial responsibility listed in this document.

Patient/Legal Representative Signature Date Time

Legal Representative Name Relationship Social Security Number

LIGHTHOUSE PSYCHIATRY

NON-CLINICAL INFORMATION RELEASE

This form **IS** for permission to communicate only information related to scheduling/appointments, billing/charges/financials, or transportation. This form **EXCLUDES** release of **PROTECTED HEALTH INFORMATION** related to direct medical/clinical treatment diagnosis, assessment, evaluation, plan and management.

PLEASE SELECT ONE OPTION FROM BELOW:

[ ] I choose to **NOT ALLOW ANYONE** receive information related to appointment scheduling, transportation, and/or billing information.

- With EXCEPTION in a life-threatening emergency, this statement will remain true.

[ ] I choose to **ONLY ALLOW PERSONS LISTED BELOW** to receive information related to appointment scheduling, transportation, and/or billing/financial information.

- I understand this authorization may be REVOKED AT ANY TIME.
- No aspects of clinical information will be released to individual on this form without additional authorization through the release of personal health information form.

FULL NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

By signing this document, I have read, understand and agree to the stipulation above. I agree that photocopies of this document are as legally binding as the original copy.

Patient/Legal Representative Signature | Date | Time

Legal Representative Name | Relationship