LIGHTHOUSE PSYCHIATRY
ADVANCED TMS & COUNSELING
a beacon for recovery and discovery
Tel: (480) 565-6440 Fax: (480) 454-1085 TMS@LHpsych.com
www.LighthouseTMS.com

HOW TO ENROLL AS NEW PATIENT

STEP 1: SCHEDULE AN APPOINTMENT

STEP 2: COMPLETE THE ONLINE ONPATIENT PORTAL (PRIOR TO ARRIVING FOR APPOINTMENT)

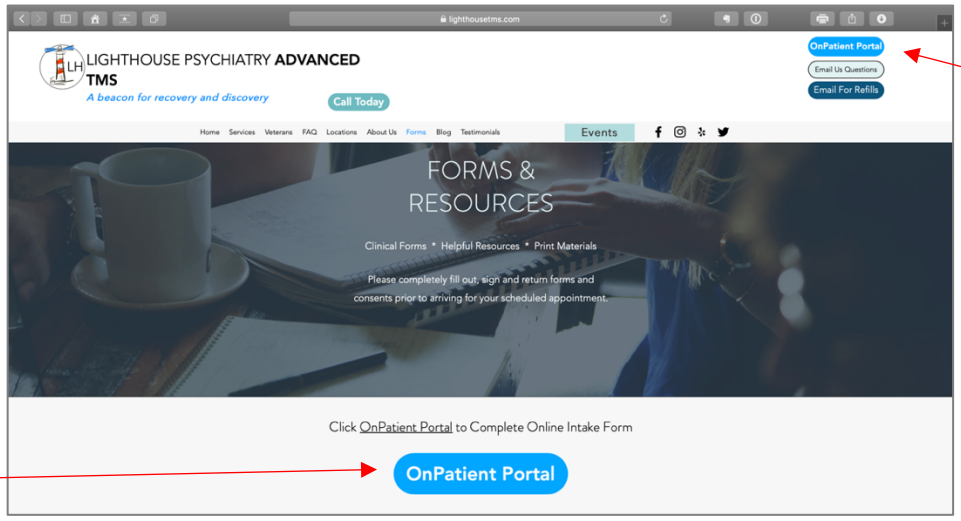
STEP 3: SIGN FACILITY CONSENTS & POLICY FORMS (ON DAY OF APPOINTMENT)

Please follow instructions for online OnPatient Portal access

OUR CLINIC HAS TRANSITIONS TO AN ONLINE PLATFORM FOR COMPLETING NEW PATIENT INFORMATION. PLEASE FOLLOW THE INSTRUCTIONS BELOW TO ACCESS OUR ONLINE ONPATIENT PORTAL.

1. Once an appointment is scheduled, you will receive a confirmation email to sign-up/login to the online OnPatient Portal at http://onpatient.com. You can also access portal by visiting our website at https://www.lighthousetms.com
2. To sign-up on Onpatient Portal, you will need to know your Date of Birth AND phone number (used to register).
3. In OnPatient Portal, navigate to your scheduled appointment, Check-In, and complete intake form.
4. You can also use OnPatient Portal to view future appointments.
5. IF YOU DO NOT have access to a computer or printer, YOU WILL NEED TO COME TO THE OFFICE AT LEAST **45 MINUTES EARLY** to complete the Onpatient Portal, in addition to, signing consents and the rest of the registration process PRIOR to seeing the provider.
6. IF FORMS ARE NOT COMPLETED, YOUR APPOINTMENT MAY BE CANCELLED AND RESCHEDULED TO ANOTHER DATE AND TIME.

1



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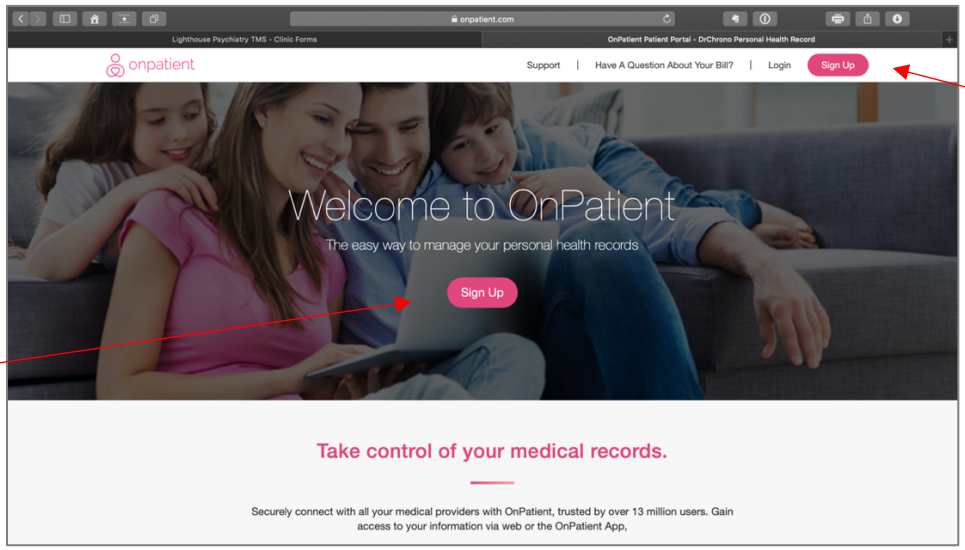

Please follow instructions for NEW PATIENT enrollment

1. Schedule appointment
2. Check your email for link to access online OnPatient Portal.
3. PRIOR TO ARRIVING FOR SCHEDULED APPOINTMENT, complete the online OnPatient intake form.
4. ON DAY OF SCHEDULED APPOINTMENT, arrive EARLY to appointment.
    A. IF YOU COMPLETED ONLINE INTAKE, please arrive **15-20 MINUTES EARLY** to allow time to check-in, register as new patient, fill out additional paperwork, sign consents, and allow staff to complete registration process.
    B. IF YOU DID NOT COMPLETE ONLINE INTAKE, please arrive **45 MINUTES EARLY** to allow time to complete online OnPatient Portal in the office PRIOR to seeing provider.
    C. You will be considered LATE AND MAY NEED TO RESCHEDULE if the extra time it takes to register and/or complete paperwork leads to you being late to be seen by provider. Hence, we seriously encourage you to be early for your scheduled appointment.
    D. For INTAKES, your appointment will be cancelled and rescheduled if you are LATE 20 MINUTES.
    E. For FOLLOW-UPS, your appointment will be cancelled and rescheduled if you are LATE 8 MINUTES.
    F. BRING with you the following materials to your scheduled appointment:
        1) CURRENT insurance cards
        2) Photo ID (government issued)
        3) Referral Form from your PCP (If required by your health insurance)
        4) IF PATIENT IS A MINOR OF DIVORCED PARENTS, please bring copy of the divorce court order/summary
        5) IF APPOINTMENT IS FOR TMS EVALUTION OR MEDICATION MANAGEMENT, please bring copy of past and current medication history (must include drug name, dose, duration, side effects)
5. REMINDERS:
    A. You must complete all online OnPatient Portal forms BEFORE being seen by provider
    B. You must pay balance based on your verified insurance benefits BEFORE being seen by provider
    C. DO NOT BE LATE. Our LATE POLICY is as follows:
        i. For INTAKE appointments, if you are LATE 20 minutes or more, then your appointment may be cancelled, you will be rescheduled AND a $150 administrative fee may be imposed on next visit.
        ii. For FOLLOW-UP appointments, if you are LATE 8 minutes or more, then your appointment will be cancelled, you will be rescheduled AND a $75 administrative fee may be imposed on next visit.

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NOTICE OF GENERAL CONSENT TO TREAT, PRIVACY PRACTICE, HIPAA DISCLOSURE, AND PRACTICE POLICY & PROCEDURES

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. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION AND POLICY & PROCEDURES

Your protected health information may be used and disclosed by your physician, our office staff and others 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.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

CONSENT FOR 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 another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

CONSENT FOR REMOTE/VIRTUAL TELEHEALTH TREATMENT: In addition to on-site treatment, we offer remote/virtual telehealth treatment. To receive telehealth services, I understand, acknowledge, and agree to the following restrictions: 1) limitations, risks, expectations, and my responsibility in complying to treatment and crisis intervention by 3rd party crisis intervention team and/or local police, 2) establish and maintain confidentiality during my electronic communication during treatment session, 3) provide address of current location when treatment begins and my contact information in event of loss communication, 4) in the event of an emergency or crisis, I will contact and/or be contacted by crisis team and/or police, 5) confirm my identity at the start of each telehealth treatment session, 6) conduct telehealth treatment session in a space or room free of another person present able to witness or hear session details, unless otherwise requested by provider, and 7) maintain personal responsibility of compliance to treatment and care deemed appropriate by provider.

CONSENT FOR MINORS: I understand that, for minors entering treatment, decisions about psychiatric, other behavioral health and 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.

CONSENT FOR MINORS OF DIVORCED/SEPARATED PARENTS: In the 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 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 of this in order for the psychiatric evaluation to occur as scheduled. Both parents, regardless of custody, have a legal right to medical records. Custody documents are required and must be presented prior first appointment.

CONSENT TO OBTAIN MEDICATION HISTORY: I agree that clinic may request and use my prescription medication history from other providers, state databanks, pharmacies, and/or third-party payers for treatment purposes.

REGISTRATION: 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.

Co-pays, deductibles, or any outstanding amounts on the client's account are due and payable prior to the client's appointment and will be collected prior to services being rendered; a follow-up appointment will not be scheduled if there is a balance due, UNLESS the provider determines that the client is in an emergency situation, in which case, a follow-up appointment will be provided and the client will be given a 30-day written termination notice. An outstanding balance on the client's account includes no show and/or late cancellation fees that have not been collected.

New clients will be provided a written statement regarding the clinic's billing policies, termination policy, and no-show/cancellation policy; they will sign this statement to indicate they have read it and acknowledge the clinic's operating practices. The client may receive complete copies of these policies, at his/her request. It is the client's responsibility to read the policy.

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. I agree to inform clinic if I DO NOT allow nonsecure communications. I have been informed of 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.

LIMITATIONS ON INSURANCE COVERAGE: I understand that clinic will make good-faith attempts to verify my insurance coverage as a courtesy when possible prior to my first appointment and any coverage issues will be communicated to me; however, I understand that this is not a guarantee of coverage and any charges not paid by the insurance company may be my responsibility including deductibles, copays, disallowed charges, and adjudicated amounts. If prior authorization for services is needed, I understand that it is my responsibility to notify clinic in advance and that charge denied due to lack of authorization may be my responsibility.

PATIENT/GUARDIAN RESPONSIBILITY FOR PAYMENTS: I agree to pay any charges due including copays, deductibles, and outstanding balances prior to each visit, and understand that I may not be scheduled for follow-up appointments while there is a balance due; if I am seen emergently while in arrears, I understand that I may be given a 30-day termination notice at the discretion of the provider and clinic.

CONSENT TO MAINTAIN AND CHARGE CREDIT/BANK ACCOUNT ON FILE: I 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 agree that 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.

SELF-PAY AND OUT-OF-NETWORK BENEFITS: I understand that I have a right to self-pay for my care and forgo insurance coverage. 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.

NONCOVERED SERVICES: 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.

AHCCCS/MEDICAID: I understand clinic is not a designated AHCCCS/Medicaid provider and hence do not bill AHCCCS/Medicaid for services rendered. I agree to be financially responsible for all patient responsibility payments not covered by the primary insurance. I understand I will not be seen if and/or when AHCCCS/Medicaid becomes my primary insurance. I understand clinic only accepts AHCCCS/Medicaid as a secondary insurance and I must have a primary commercial insurance plan that is non-AHCCCS/Medicaid based. I agree to disclose to clinic if I have AHCCCS/Medicaid and, in the event that I don't, I understand that I will be discharged.

MEDICARE: I understand clinic is not a designated Medicare provider and hence do not bill Medicare for services rendered. I agree to be financially responsible for all patient responsibility payments not covered by the primary insurance. I understand I will not be seen if and/or when Medicare becomes my primary insurance. I agree to disclose to clinic if I have Medicare and, in the event that I don't, I understand that I will be discharged.

COOPERATION WITH ONLINE PATIENT PORTAL ASSIGNMENTS: I will establish a secure patient portal account through the clinic's Electronic Medical Record (EMR). I am responsible for completing assignments indicated by my provider prior to each visit. If assignments are not completely prior to appointment, I understand and acknowledge that I may not be seen and a potential NO SHOW fee to be charged to me. I understand that, if I arrive 45 minutes prior to the session, it may be possible to complete the assignments at the clinic provided that a computer is available.

DISABILITY, FMLA, AND OTHER FORMS: 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 less than 3 encounters. When forms are filled out at the provider's discretion, there will be a minimum charge of $20 per page. Please note rates and policy subjected to change without notice.

COURT AND LEGAL 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.

CONTROLLED SUBSTANCES: 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 medications.

PROHIBITED ITEMS: I understand that no firearms, vaps/e-cigarettes, weapons, illicit substances, or alcohol may be brought onto the premises, and that violations may be grounds for immediate termination and prosecution.

LABORATORY TESTING: 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.

REFILLS: It is the client's responsibility to make refill requests 7 days before running out of medications. Urgent refills are only filled at the discretion of the provider.

SUPERVISORY RELATIONSHIPS: I understand that in some cases unlicensed providers or therapists may provide treatment under a supervisory relationship with a licensed provider, and that clinic will inform patients of such circumstances prior to treatment by an unlicensed practitioner, trainee, etc. I understand that I have a right to refuse treatment, but that alternative licensed providers may not be available.

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION USED FOR RESEARCH: I acknowledge and understand that clinic on occasion do participate 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. My clinical data will be aggregated with other datasets, data points, and databases to generate statistical information for the sole purpose of research and academic reasons. I understand that my personal health information will never be published. I understand the research will not interrupt or interfere with my ongoing or existing treatment. I understand that certain research projects may offer compensation for select participation.

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION USED FOR EDUCATIONAL AND/OR TRAINING PURPOSES: I acknowledge and understand that clinic on occasion do participate in educational and/or training of professionals and can use my demographical and clinical information for teaching purposes only. I understand trainees are trained to understand and subject to follow strict guidance of clinic HIPAA and PHI policies. I understand this will not interrupt or interfere with my ongoing or existing treatment.

TERMINATION: I understand that I may terminate treatment at any time and request that their medical records be sent to another provider. clinic may terminate treatment for reasons including but not limited to: it is determined that inadequate expertise or facilities are available to treat the condition; a higher level of care is required (eg intensive outpatient, residential, or hospital-based treatment) for safety or acuity; the agreed upon treatment plan is not adhered to due to poor and/or lack of treatment compliance; withholding or misrepresentation of important information; misuse of prescribed medication; multiple no-shows or cancellations; failure to satisfy payment of outstanding bills; repeated failure to pay for service; or threatening, obscene, belligerent, or otherwise disruptive behavior. 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 or inappropriate behavior that do not allow for any ongoing productive treatment relationship. I understand it is the discretion of the admitting provider, clinical director, and/or medical director, to allow reactivation and re-enrollment back into clinic services.

EMERGENCIES: Our clinic and its subsidiary locations DO NOT manage acute crisis and psychiatric emergencies. If you are experiencing a true emergency, please dial 911. Messages left on our voicemail will be answered within one business day (or next business if. Message received after Friday closing). Matters requiring a call back may be left with voicemail menu to be triaged by a staff member; only truly urgent calls will be forwarded to the physician on call. Help can also be sought from:

Psychiatric Urgent Care Facilities:	*Crisis Lines:*
Connections Arizona (UPC): 502-416-7600	National Suicide Crisis Hotline: 800-273-TALK
Recovery Innovations of Arizona: 602-650-1212	Maricopa County Crisis Response Network: 800-631-1314 or 602-222-9444
Banner Psychiatric Center: 480-448-7600	Empact Crisis: 480-784-1500

PAYMENT: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

NO SHOW/LATE CANCELLATION POLICY: Clients who fail to show for an appointment or do not provide 24-hour notice of cancellation will be assessed a non-negotiable administrative fee to be applied to appointment scheduled. Lighthouse Psychiatry can be reached at all times for greater than 24-hour cancelling and/or rescheduling appointments at 480-565-6440; a message may be left on a business day. Please note that a message left on the weekend may not count toward the 24-hour notice.

Fees include $150 (intakes) and $75 (follow-up) to be applied to appointment scheduled. Please note rates subject to change without notice.

No show/late cancellation fees are not negotiable. Any exceptions to policy require approval by clinic management.

If client has multiple incidences of no-show and/or late cancellation (within 24-hour notice), services to client will be terminated effective 30 days from mailing date of notice. Any exceptions to policy require approval by clinic management.

BILLING AND PAYMENT POLICY: Residual amounts due after insurance adjudication will be billed directly to the client and are the client's financial responsibility. Payment is due prior to services being rendered.

If a refund is owed to the client, the refund will be paid within approximately 6-8 weeks of adjudication.

Lighthouse Psychiatry bills the client's insurance company as a *courtesy* to the client. The client's insurance benefits are a contract between the client and the client's insurance company. It is the client's responsibility to verify their mental health benefits. If benefits are exhausted, the client is liable for all charges incurred. Whatever disagreements the client has with his/her insurance company including benefit information; it is the client's responsibility to contact their insurance company to resolve. It is the policy of Lighthouse Psychiatry that Lighthouse Psychiatry collects any

amounts as verified through the client's insurance company, such as co-pays or deductibles. Lighthouse Psychiatry will not make multiple verifications if the client disagrees with the information obtained from the insurance company. It is the client's responsibility to contact their insurance company if there are any discrepancies.

If there are billing issues, please contact clinic billing department at (480) 485-9169.

For self-paying clients who are filing their own claims with insurance companies with which Lighthouse Psychiatry is not affiliated, the client will be issued a copy of the encounter form that specifies all criteria needed for insurance companies to process the claim for their member and a receipt of payment.

Lighthouse Psychiatry is accepting self-pay clients. All payments for services are due and payable prior to services being rendered.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your 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 your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our clinic to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

REQUIRED BY-LAW: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

PUBLIC HEALTH: We may disclose your 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.

COMMUNICABLE DISEASES: We may disclose your 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.

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

ABUSE OR NEGLECT: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you 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.

FOOD AND DRUG ADMINISTRATION: We may disclose your 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.

LEGAL PROCEEDINGS: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

LAW ENFORCEMENT: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We 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.

CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your protected health information, if we 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. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY ACTIVITY AND NATIONAL SECURITY: When the appropriate conditions apply, we 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.

WORKERS' COMPENSATION: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

INMATES: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT REQUIRE PROVIDING YOU THE OPPORTUNITY TO AGREE OR OBJECT: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

OTHERS INVOLVED IN YOUR HEALTH CARE OR PAYMENT FOR YOUR CARE: 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.

RELEASE OF MEDICAL RECORDS: Lighthouse Psychiatry will make every attempt to obtain medical records on all new clients prior to their first appointment.

It is at provider's discretion to complete the client evaluation upon the first appointment if Medical Records have not been provided by the client.

In a situation where a more recent psychiatric evaluation or treatment is not disclosed during the screening process, clinic will require receipt of the medical records prior to a second appointment being scheduled.

COPIES OF MEDICAL RECORDS FOR <u>PERSONAL</u> USE requested by clients is $25 for the first 20 pages. An additional $0.25 per each additional page will be applied after the first 20 pages. Please note that rates subject to change without notice.

***COPIES OF MEDICAL RECORDS FOR <u>COORDINATION OF CARE</u> OR <u>INSURANCE CLAIM</u> USE** are executed without charge to client.

FACILITY DIRECTORIES: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

SOCIAL MEDIA AND MARKETING POLICY DISCLAIMER: Published (digital and print) content on clinic social media, website, and other materials are solely for educational and marketing purposes only and is not a replacement nor confirmation of delivery of professional services. Customized and targeted professional services are still delivered in a scheduled appointment with a provider.

Past and present clients risk breaching confidentiality by following or commenting on published clinic content presented online and/or social media platform.

Clinic will not "friend" or "follow" current or past clients to honor ethical boundaries and privacy policy. If done so in error, I agree to notify clinic.

Clinic does not use social media to require or request testimonial, rating or endorsement from clients.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how to exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

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 health care 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 restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your 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 we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your 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. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

***PLEASE NOTE ANY RATES AND POLICY DETAILS ARE SUBJECT TO CHANGE WITHOUT NOTICE.**

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 electronically.

By signing this document (by paper or electronically), 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 Name	Patient Signature	Date
Guardian Name (if applicable)	Guardian Signature	Relationship

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REMOTE/VIRTUAL TELEHEALTH AGREEMENT

To receive telehealth services, I understand, acknowledge, and agree to the following restrictions:

1) limitations, risks, expectations, and my responsibility in complying to treatment and crisis intervention by 3rd party crisis intervention team and/or local police

2) establish and maintain confidentiality during my electronic communication during treatment session

3) provide address of current location when treatment begins and my contact information in event of loss communication

4) in the event of an emergency or crisis, I will contact and/or be contacted by crisis team and/or police

5) confirm my identity at the start of each telehealth treatment session

6) conduct telehealth treatment session in a space or room free of another person present able to witness or hear session details, unless otherwise requested by provider

7) maintain personal responsibility of compliance to treatment as established by provider

8) telehealth services may be terminated if compliance becomes problematic and/or detrimental to treatment

I understand and acknowledge that I will not be able to continue telehealth services 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.

By signing this document (by paper or electronically), 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.

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CONSENT FOR TREATMENT OF MINOR WITH DIVORCED/SEPARATED PARENTS

General consent for patient who is a minor, under the age of 18 years old, whose parents are divorced or separated.

Legal Custody/Divorce Decree documents must be provided at patient's FIRST APPOINTMENT PRIOR to minor being seen by provider WITHOUT EXCEPTION.

PLEASE SELECTION ONE OPTION BELOW:

[ ] **Patient is a minor** whose parents are **DIVORCED/SEPARATED WITH 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.

[ ] **Patient is a minor** whose parents are **DIVORCED/SEPARATED WITH SOLE CUSTODY** in matters of medical treatment AND the non-accompanying parent has **NO LEGAL** authority in making medical decisions for minor.

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 (if applicable)	GUARDIAN Signature	Relationship

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BEHAVIORAL HEALTH CONTROLLED SUBSTANCE AGREEMENT

The purpose of the agreement is to prevent misunderstandings about prescription medications that have the potential for abuse and dependence. These medications fall into two different categories:

A. Anti-anxiety medicines used for the treatment of anxiety, panic and insomnia.
B. Psycho-stimulant medicines used for the treatment of attention deficit disorders and depression.

I UNDERSTAND AND ACKNOWLEDGE THAT I FULLY COMPLY TO STIPULATIONS LISTED BELOW FOR ME TO RECEIVE MEDICATION TREATMENT AT CLINIC.

I understand that if I am prescribed medications that fall into those categories listed above, I will be assessed at risk for abuse or dependence.

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.

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.

I will NOT use any illegal controlled substances, including cocaine, methamphetamine, etc.

I will NOT attempt to obtain anti-anxiety medicine or psycho-stimulants from any other doctor.

I will notify my doctor immediately if I obtain controlled substances as such as pain medications, including medical marijuana, from any other doctor.

I will NOT share, sell or trade my medication with anyone.

I will safeguard my prescriptions and controlled medications from loss or theft. Lost or stolen medicines will not be replaced.

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.

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.

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.

I agree not to mix my medications with alcohol.

I agree to designate the use of one pharmacy. Refills will be obtained by written prescription only, during regular office hours.

I agree to follow these guidelines that have been fully explained to me.

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.

By signing this document (by paper or electronically), 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.

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POLICY ON COURT RELATED SERVICES

Client understands 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 and client.

Attorney issuing the subpoena will contact the office, **at least 4 weeks in advance of the court date,** and will need to define a 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 of **$265 per hour,** for any part of an hour. "STANDBY" is described as time provider must wait for a telephonic appearance.

APPEARANCE fees are billed at court rate of **$450 per hour,** for any part of an hour. "APPEARANCE" includes telephonic testimony, and/or actual time in the court, or legal office building, or building where deposed.

DEPOSITION fees are billed at **$650 per hour** for the first four hours, then **$450 per hour** for any part of every hour thereafter.

RECORD REVIEW, SUBPOENA RESPONSE, REPORT WRITING fees are billed at **$350 per hour**, minimum of 4-hour block, to be paid in advance.

MILEAGE fees for traveling are billed at **$2 per mile** traveled.

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 services in advance and any amount not used will be returned within 15 business days after the 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 progress 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 fee will be billed at the rate of $350.00 per hour, four hours to be paid in advance.

Summary of other Court/legal related services are charged as follows:

• Telephone Consultation	per hour	$450.00
• Appearance/Court Testimony	per hour	$450.00
• Record review, subpoena response, report writing	per hour	$350.00
• Client/attorney or attorney staff consultation	per hour	$450.00
• Deposition billed in 4-hour increments	per hour	$650/$450
• Conciliation consultation (parenting advisors, etc.)	*NOT AVAILABLE*	*NOT AVAILABLE*
• Therapeutic visitation (4 hours paid in advance)	*NOT AVAILABLE*	*NOT AVAILABLE*
• Travel Mileage	per mile	$2.00

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 services in advance and any monies not used will be returned within 15 business days after the final judgment in the case.

If court case is continued, the doctor/therapist'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 progress notes are not released without a judge's order. However, the doctor or therapist will provide a written report and case summary with the appropriate signed consents, if so ordered by the court. As listed above, the report fee will be billed at the rate of $350.00 per hour, four hours to be paid in advance.

By signing this document (by paper or electronically), 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.

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Guardian Name (if applicable)	Guardian Signature	Relationship

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FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

1. I acknowledge and understand LIGHTHOUSE ONLY accepts and in-network with commercial insurance.
2. I acknowledge and understand LIGHTHOUSE DO NOT ACCEPT AND DO NOT FILE CLAIMS to **MEDICAID, AHCCCS, MERCY CARE, and similar agencies.**
3. I acknowledge and understand LIGHTHOUSE DO NOT ACCEPT AND DO NOT FILE CLAIMS to **MEDICARE**.
4. I acknowledge and understand I WILL NOT SUBMIT SUPERBILLS to **MEDICARE, MEDICAID, AHCCCS, MERCY CARE, and similar agencies**.
5. I acknowledge and understand I am responsible for notifying LIGHTHOUSE if I have **MEDICARE, MEDICAID, AHCCCS, MERCY CARE, and similar policies** as a primary or secondary.
6. I acknowledge and understand I may be DISCHARGED from LIGHTHOUSE if I purposefully do not disclose having **MEDICARE, MEDICAID, AHCCCS, MERCY CARE, and similar policies.**
7. I acknowledge, understand and ACCEPT FULL FINANCIAL RESPONSIBILITY for ALL SERVICES rendered by LIGHTHOUSE.
8. I acknowledge, understand and accept that PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE unless other definite and financial arrangements have been made and agreed upon by LIGHTHOUSE management prior to treatment.
9. I acknowledge, understand and accept to pay all reasonable attorney fees and collection costs in the event of DEFAULT OF PAYMENT of my charges.
10. I authorize and request that insurance payments be made directly to LIGHTHOUSE when using my health insurance carrier.
11. I acknowledge, understand and accept BENEFITS VERIFICATION of my health insurance performed by clinic is a COURTESY (NOT REQUIREMENT).
12. I acknowledge, understand and accept that it is MY RESPONSIBILITY, as the policy holder, to ensure approval and accuracy of INSURANCE COVERAGE AND BENEFITS OF SERVICES provided to me by LIGHTHOUSE. I understand it is a COURTESY (NOT REQUIREMENT) from clinic to assist me in this process.
13. I acknowledge, understand and accept that ANY DISPUTES OF COVERED BENEFITS ARE MY DIRECT RESPONSIBILITY to resolve with my insurance company. I understand that it is a COURTESY (NOT REQUIREMENT) from LIGHTHOUSE to assist me in this process.
14. I acknowledge, understand and accept that my health insurance policy is a contract between me (the patient and policy holder) and the insurance company and/or my employer. This contract has NO RELATIONS to Lighthouse and its affiliates.
15. I acknowledge, understand and accept that it is MY RESPONSIBILITY TO UPDATE Lighthouse of any CHANGES TO MY INSURANCE, including, but not limited to, policy, ID, carrier, subscriber, address, or any other information.
16. **I acknowledge, understand and accept the clinic NO SHOW/LATE CANCELLATION POLICY of imposing the following:**
    a) **$150 FEE PER INTAKE and $75 FEE PER FOLLOW-UP.**
    b) This fee is SEPARATE and INDEPENDENT from fees associated with professional services rendered by provider and/or clinic.
17. **I acknowledge, understand and accept Lighthouse may DISCHARGE me from the clinic for TWO OR MORE CONSECUTIVE INCIDENTS OR PRESENCE OF HABITUAL INCIDENTS of NO SHOW/LATE CANCELLATION**.
18. I acknowledge, understand and accept that 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, or any other outstanding balances.
19. I acknowledge, understand and accept I am solely responsible for keeping track of my appointments and scheduling obligations, as well as, any fees accrued for missed appointments. I understand APPOINTMENT REMINDERS provided by clinic is a COURTESY (NOT REQUIREMENT) from LIGHTHOUSE.
20. **I acknowledge, understand and accept that MY DEBIT/CREDIT CARD WILL BE PUT ON FILE for convenient payment of charges accrued.**
21. I have READ AND FULLY UNDERSTAND the above financial responsibility and insurance authorization.

By signing this document (by paper or electronically), 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.

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Guardian Name (if applicable)	Guardian Signature	Relationship

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CREDIT CARD AUTHORIZATION FORM

COMPLETION, SIGNING AND AGREEING TO THIS FORM ARE REQUIRED FOR SERVICES TO BE RENDERED AT LIGHTHOUSE PSYCHIATRY TMS.

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:	

1. I acknowledge, understand, and authorize LIGHTHOUSE PSYCHIATRY TMS and its affiliates/subsidiaries to charge my debit card or credit card above for agreed upon purchases.
2. I acknowledge and understand that my card information will be saved on file for future transactions on my account.
3. **I ACKNOWLEDGE AND UNDERSTAND MY CARD INFORMATION WILL BE STORED SECURELY:**
   - **a) IN A SECURE ON-SITE LOCATION**
   - **b) ON A SECURE ELECTRONIC MEDICAL/HEALTH RECORD COMPANY'S SERVER**
   - **c) ON A SECURE CREDIT CARD PROCESSING COMPANY'S SERVER**
4. I acknowledge and understand an internal privacy and security manager will routinely surveillance and monitor for breach of security and personal and financial information. I will be immediately notified of any known breach and/or leak of my personal financial information.
5. I acknowledge and understand this authorization will remain in effect until I am no longer an active client of LIGHTHOUSE.
6. I acknowledge and understand I will be notified in writing of any executed transaction on the card.
7. I acknowledge and understand this form is to offer a simple, convenient and complementary solution to make repeated payments for professional services rendered and administrative charges accrued, including, but not limited to, CO-PAYS, DEDUCTIBLES, COINSURANCES, ADMINISTRATIVE FEES, NO SHOW/LATE CANCELLATIONS, and any other fees.
8. I acknowledge and understand I CAN CHOOSE an alternative form of payment and not execute this agreement.
9. I acknowledge and understand I have the RIGHT TO NOT SIGN this agreement, but clinic may execute option to NOT OFFER services.
10. I acknowledge and understand completing, signing and agreeing to this document is REQUIRED PRIOR TO SERVICES RENDERED.

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

PATIENT Name _____ PATIENT Signature _____ Date _____

GUARDIAN Name (if applicable) _____ GUARDIAN Signature _____ Relationship _____

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PERMISSION TO COMMUNICATE WITH FAMILY, FRIENDS, AND/OR SELECT INDIVIDUALS

- *This form **IS NOT** a release of **PROTECTED HEALTH INFORMATION AND CLINICAL INFORMATION**. A separate form is REQUIRED to discuss and/or share clinical information.*
- *This form is for permission to communicate information related to **ONLY** patient's **SCHEDULING, TRANSPORTATION,** or **BILLING/FINANCIAL INQUIRY**.*

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.

NOTE TO PARENTS: If your child is **over 18 years of age *(considered an ADULT)*** and **you are NOT their legal guardian**, this form **MUST** include you for us to be able to discuss your child's appointment schedule, transportation, and/or billing/financial information.

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 Name | Patient Signature | Date

Guardian Name (if applicable) | Guardian Signature | Relationship

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION		
Patient Name:	Gender: [ ] Male [ ] Female	DOB:
Home Address:		

AUTHORIZATION

LIGHTHOUSE PSYCHIATRY ADVANCED TMS
4001 EAST BASELINE ROAD SUITE 204, GILBERT, ARIZONA 85234
TMS@LHpsych.com Tel: (480) 565-6440 Fax: (480) 454-1085

I authorize the release and disclosure of my Protected Health Information between LIGHTHOUSE (all providers and staff) and the following:

[ ] MEDICAL FACILITY [ ] PERSON (family, friend) [ ] LEGAL ENTITY [ ] OTHER _____

Facility:		
Name:		Relationship:
Address:		
Email:	Telephone:	Fax:

INFORMATION RELEASED INCLUDE:

[ ] ALL MEDICAL RECORDS [ ] TREATMENT/PROGRESS NOTES [ ] MEDICATION LIST [ ] HOSPITAL RECORDS
[ ] LAB RESULTS [ ] IMAGING RESULTS [ ] TEST RESULTS [ ] DISCHARGE SUMMARY
[ ] OTHER _____

REASON FOR RELEASE OF INFORMATION:

[ ] COORDINATION/CONTINUITY OF CARE [ ] TRANSFER OF CARE [ ] INSURANCE [ ] LEGAL [ ] PERSONAL
[ ] OTHER _____

DATES NEEDED: 1 (ONE) YEAR	**IF OTHER DATES NEEDED, PLEASE SPECIFY:**

1. I understand that my Protected Health Information may contain information relating to Sexually Transmitted Diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care, Psychiatric Care, treatment of alcohol/drug abuse and genetic testing.
2. I understand that my treatment from clinic is not contingent on my signing this authorization. The clinic will not deny me treatment if I do not wish to sign.
3. I understand that the information released may no longer be protected by state and federal regulations and may be redisclosed by the authorized recipient.
4. I understand I may revoke this authorization at any time by simply submitting a written request to **LIGHTHOUSE**.
5. I understand this AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED, if not revoked prior to expiration date.
6. I release **LIGHTHOUSE**, all providers and staff, from any legal liability for the release of information in accordance to the above authorization.
7. I understand a SURCHARGE rate may apply to release and distribute PHI to entity above, exception treating medical professionals and health insurance carriers. **[RATE FOR COPIES OF MEDICAL RECORDS: $25 for the first 20 pages and $0.25 per each additional page]**

By signing this form, I, the patient, authorize release of my protected health information, including a copy of my medical records, and/or a summary or narrative of my protected health information, BILATERAL communication between LIGHTHOUSE and the entity authorized above.

PATIENT Signature Date

GUARDIAN Name (if applicable) GUARDIAN Signature Relationship