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

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 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.

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/MEDICARE: I understand clinic is not a designated AHCCCS/Medicaid/Medicare provider and hence do not bill AHCCCS/Medicaid/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 AHCCCS/Medicaid becomes my 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.

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/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.

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 addictive and/or controlled 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.

CLINICAL RESEARCH: I acknowledge and understand that clinic on occasion do participate in research projects and can use my demographical and clinical information for research. My data will be de-identified, combined with other people's data and other databases to generate statistical information for the sole purpose of research. My personal health information will never be published. I understand any ongoing research will not interrupt, interfere, or compromise my existing treatment.

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: treatment ineffectiveness; higher level of care is required; non-compliance to treatment plan; loss of patient-provider trust from withholding or misrepresentation of important clinical information compromising patient care; misuse of prescribed medication; multiple no-shows or cancellations; failure to satisfy financial responsibility and obligation; or display of abusive, threatening, obscene, belligerent, or otherwise disruptive behavior. Written 30-day notice of termination will be issued to patient.

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. Our messaging is not equipped to manage crisis or clinical emergencies. Help can also be sought from:

National Suicide Crisis Hotline: 800-273-TALK, or Maricopa County Crisis Response Network: 800-631-1314 or 602-222-9444

NO SHOW/LATE CANCELLATION POLICY: Clients who fail to show for an appointment or do not provide 24-hour notice of cancellation will be assigned a non-negotiable administrative fee. Cancelling and/or rescheduling appointments can be done by calling 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. Two (2) or more incidences of

consecutive no show/late cancellation may subject patient to termination of service and be discharged from clinic. Any exceptions to policy require approval by clinic management.

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. We will have a written contract that contains terms that will protect 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.

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.

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.

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.

FEES

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

NO SHOW/LATE CANCELLATION: A $150 fee for INTAKES and a $100 fee for FOLLOW-UPS.

PREPARING, COPYING, AND SENDING OF MEDICAL RECORDS FOR <u>PERSONAL</u> USE: Fee as follows: $25 for the first 20 pages, with $0.25 per each additional page.

LEGAL/COURT/DEPOSITION FEES: Rates reported in separate "Court Policy" acknowledgement.

CONSULTING FEES: Rates reported in separate policy.

PAPERWORK FOR DISABILITY, FMLA, LETTERS, AND OTHER DOCUMENTS: Fee of $20 per page completed.

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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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 you are 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.

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
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REMOTE/VIRTUAL TELEHEALTH AGREEMENT

To receive telehealth services, I understand, acknowledge, and agree to the following limitations, risks, expectations, and responsibilities:

1) Establish and maintain confidentiality during my electronic communication during treatment session.

2) Provide physical address of current location when treatment session begins.

3) Provide my contact information in event of loss communication.

4) 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.

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 plan as established by provider.

8) Telehealth services may be terminated if compliance to treatment plan and/or scheduling becomes problematic and/or detrimental to overall treatment plan and goal.

9) Fulfill any financial responsibilities (current or delinquent) prior to entering scheduled telehealth session.

10) 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, acknowledge, and agree that my telehealth services will be discontinued if I compromise any stipulation above.

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 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.

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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AHCCCS, MEDICAID & MEDICARE ACKNOWLEDGEMENT

PLEASE INITIAL EACH ITEM AND SIGN AT THE BOTTOM OF THE FORM TO ACKNOWLEDGE, UNDERSTAND, AND ACCEPT ALL RESPONSIBILITIES DEFINED IN THIS DOCUMENT.

INITIAL HERE:	STATEMENTS OF ACKNOWLEDGEMENT:
	I acknowledge and understand LIGHTHOUSE DOES NOT ACCEPT **Medicare, AHCCCS, Medicaid, or Mercy Care plans,** because Lighthouse DOES NOT have a contract for reimbursement with **Medicare, AHCCCS, Medicaid, or Mercy Care**.
	I acknowledge I, the patient, DO NOT HAVE or CHOOSE NOT TO USE a **Medicare, AHCCCS, Medicaid, or Mercy Care plan.** Hence, I WILL NOT ATTEMPT TO COLLECT REIMBURSEMENT BY SUBMITTING MY SUPERBILL(S) to **Medicare, AHCCCS, Medicaid, or Mercy Care.**
	Lighthouse does accept some, case-by-case, **MEDICARE SUPPLEMENT plans**, that do not require a Medicare contract, based on initial verification from supplement insurance company. I understand if I proceed with care at Lighthouse, I will be financially responsible for any services rendered if Lighthouse does not receive reimbursement from the SUPPLEMENT insurance company. I understand Lighthouse WILL NOT send any claims to Medicare.
	Lighthouse does accept some, case-by-case, **secondary AHCCCS plans**, that do not require an AHCCCS contract, if I have a commercial plan as my primary insurance, based on initial verification from primary insurance company. I understand if I proceed with care at Lighthouse, I will be financially responsible for any services rendered not covered by my primary commercial insurance plan. I understand Lighthouse WILL NOT send any claims to AHCCCS.
	I acknowledge, understand and ACCEPT FULL FINANCIAL RESPONSIBILITY for ALL SERVICES rendered by Lighthouse. If I cannot meet my financial responsibility, then I will be discharged from Lighthouse.

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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FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

I, _____ (PATIENT NAME) with birthdate _____ (MM/DD/YYYY), understand, acknowledge, and agree to ALL the following statements. Either I or another designated person will assume ALL financial responsibilities stipulated in this statement.

1. LIGHTHOUSE only accepts commercial insurance, Tricare, and Triwest, which are not Medicare-based or AHCCCS-based.
2. LIGHTHOUSE do not accept and do not file claims to **MEDICARE, AHCCCS, MERCY CARE, and other MEDICAID agencies.**
3. I will not submit superbills to **MEDICARE, AHCCCS, MERCY CARE, and other MEDICAID agencies**.
4. I am responsible for notifying LIGHTHOUSE if I have or plan to enroll with **MEDICARE, AHCCCS, MERCY CARE, and other MEDICAID agencies** as a primary or secondary payor.
5. I may be discharged from LIGHTHOUSE if I purposefully do not disclose having **MEDICARE, AHCCCS, MERCY CARE, and MEDICAID.**
6. I accept full financial responsibility for all services rendered by LIGHTHOUSE.
7. I authorize and request that insurance payments be made directly to LIGHTHOUSE when using my health insurance carrier.
8. It is my responsibility, as policy holder, to ensure approval and accuracy of insurance coverage and benefits of services provided to me by LIGHTHOUSE. I understand any benefits verification of my health insurance is done so as a courtesy (not requirement) for me.
9. Any disputes of covered benefits are my direct responsibility to resolve with my insurance company.
10. My health insurance policy is a contract between me (the patient) and my insurance company. This contract has no relations to LIGHTHOUSE.
11. 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.
12. I am solely responsible for keeping track of my appointments and scheduling obligations, as well as, any fees accrued for missed appointments.
13. APPOINTMENT REMINDERS provided by clinic is a COURTESY (NOT REQUIREMENT) from LIGHTHOUSE.
14. **NO SHOW/LATE CANCELLATION policy: a $150 FEE for INTAKES and $100 for FOLLOW-UPS. Payment is due by invoice or on reschedule appointment**. Fee rates subject to change without notice. Fees are not covered by insurance and are strictly patient responsibility.
15. **I may be DISCHARGED for having two (2) or more consecutive incidents or presence of habitual incidents of NO SHOW/LATE CANCELLATION**.
16. I will pay a fee to prepare and send copies of MEDICAL RECORDS whose recipient is not a clinical office or reason is not directly related to coordination of medical care. Fees will be assigned for transition of records to following, but not limited to, self, non-medical personnel, disability agency, attorney office, and workman comp agency.
17. I will pay for SPECIAL LETTERS written for the purpose of support, explanation, or recommendation, such that a provider signature is required. Letter to confirm appointment schedule is excluded from this fee.
18. 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.
19. **I acknowledge, understand and accept that MY DEBIT/CREDIT CARD WILL BE PUT ON FILE for convenient payment of charges accrued.**
20. **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.

Person Accepting Financial Responsibility		Home Address	
Signature	Relationship	Social Security Number	Date

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CREDIT CARD AUTHORIZATION FORM

THIS FORM IS REQUIRED FOR SERVICES TO BE RENDERED

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 services rendered.
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 (a) I am no longer an active client of LIGHTHOUSE, and (b) all accrued debt to the company is paid off.
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, separate from this agreement.
9. I acknowledge and understand clinic MAY NOT OFFER services to me, if I choose to exercise my RIGHT TO NOT SIGN this agreement.
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 NON-CLINICAL INFORMATION WITH AUTHORIZED PERSON

A. This form **IS NOT** a release of **PROTECTED HEALTH INFORMATION** related to direct medical/clinical treatment diagnosis, assessment, evaluation, plan and management.

B. This form **IS** for permission to communicate information related to scheduling/appointments, billing/charges/financials, or transportation.

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 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

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

AUTHORIZATION

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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

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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 Relationship

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AGREEMENT AND INFORMED CONSENT FOR COUPLES/FAMILY THERAPY

Couples/family is the client: When individual attend couples/family therapy/treatment sessions, the couple/family is considered "the client," and the mental health records therefore belong to all participating adults (age 18 years or older) in that session. This means that we will require a written consent from all adult parties involved in the sessions to disclose any information from couples/family records given to a third party.

Please be aware that a single chart will be created for the couple/family. By signing this Informed Consent, you are agreeing that the chart will be under one person's name, who is designated the "chart-holder" and insurance claims will be processed under that person. ***The designated chart-holder accepts full financial responsibility for any outstanding balance due or delinquency.***

Confidentiality: All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Those situations include but are not limited to: (a) when there is reasonable suspicion of abuse to a child or to a dependent or elder adult; (b) when the client communicates a threat of bodily injury to others; (c) when the client is suicidal; (d) when the client has been physically injured due to violence; (e) when disclosure is required pursuant to a legal proceeding.

No secrets policy: As health care professionals who are entrusted with information from all participating members in a relationship or family, we, as health care professionals and facility that offers professional services, have a policy of "No Secrets", which means that we cannot promise to protect secrets of either members from other participating member, especially if the secret is harmful and/or destructive to the process of therapy/treatment itself or undermines the agreed upon intention of therapy/treatment.

Release of Records: All participating adult members must provide their individual consent to release couples/family therapy/treatment records. If any one member does not provide consent, then the therapy/treatment session records will not be released.

Court Proceedings/Subpoena of Records: It is understood that the purpose of couples/family therapy/treatment is to improve relational satisfaction. Therefore, if both partners or family members request the provider's services, they are expected not to use information given during the therapy sessions against the other party in a judicial setting of any kind, be it civil, criminal, or circuit. Likewise, neither party shall for any reason attempt to subpoena the provider's testimony or provider's records to be presented in a deposition or court hearing of any kind for any reason, such as a divorce case or custody agreements.

Course of Therapy/Treatment: Continuity of therapy/treatment by all members of couples/family is contingent on voluntary participation assessed at each session. Any member may suspend or terminate the joint therapy/treatment at any time during course of therapy/treatment.

I certify by my signature below that I have read, fully understand, and agree to abide by the stated policies.

Designated Chart-Holder Name	Date of Birth	Signature	Today's Date
Participating Client Name	Date of Birth	Signature	Today's Date
Participating Client Name	Date of Birth	Signature	Today's Date
Participating Client Name	Date of Birth	Signature	Today's Date
Witness Name		Signature	Today's Date