ACKNOWLEDGEMENT OF PATIENT EDUCATION & MATERIALS

I acknowledge I have received education and/or materials (as applicable to my programming) on the following items and have been afforded the opportunity to ask any questions/clarifications:

- Patient orientation to Program and Premises
- Hours of operation and dispensing
- Patient Rights and BrightView Health Grievance Procedures
- BrightView's Notice of Privacy Practices and written summary of Federal confidentiality laws
- BrightView Health's guidelines and rules/regulations
- BrightView Health patient fees and billing procedures
- Financial Assistance
- Treatment options, including withdrawal management
- Benefits and risks associated with each treatment option
- Addiction treatment and pregnancy, including Neonatal Abstinence Syndrome and the risk and benefits of taking buprenorphine or methadone while pregnant, if applicable[1]
- Resources for parenting/parenting skills
- Use of voluntary long-acting reversible contraception, if applicable
- Risk of exposure, prevention & treatment of chronic viral diseases including HIV, Hepatitis, Tuberculosis, and sexually transmitted infections
- Expected therapeutic benefits and adverse effects of treatment medication
- Risk for overdose, including drug interactions with the central nervous system depressants
- Risk for overdose, including relapse after a period of abstinence from opioids
- Overdose prevention and reversal agents
- The disease of addiction
- Information regarding the patient's diagnosis
- The effects of alcohol and other drug abuse
- Family issues related to substance use disorder
- Relapse prevention
- Noncompliance and discharge procedures
- Potential drug interactions
- Toxicology testing and Phlebotomy Services Procedures
- Take Home Medications
- Crisis Services
- Severe Weather Policy
- Patient Policy Manual - Massachusetts
- Massachusetts Automated Rx Reporting System (MassPat)
- Medication Adherence Policy
- Dual Enrollment Consent
- Consent for Alcohol or Drug Assessment and Treatment
- Telemedicine Consent
- Text Consent

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

[1] For all female patients of child-bearing age and potential

PATIENT CONFIDENTIALITY AGREEMENT

Dear Patient:

BrightView Health is a confidential counseling service. BrightView Health is bound by State and Federal laws of confidentiality of both mental health and substance abuse services. Once an appointment is made, no information can be disclosed to anyone without your written permission on a Release of Information Form. When you come to your first appointment, the policy on confidentiality and your rights as a patient will be discussed in detail.

What this means for you:

BrightView Health will not share your information with a third-party without your written consent. BrightView Health staff will work diligently to protect information provided in counseling sessions.

- Confidentiality does not apply to cases of reported or suspected abuse/neglect of children or the elderly
- Confidentiality does not apply to cases of potential harm to self or others
- In cases of medical emergency, information may be shared with medical personnel
- On rare occasions, there will be a request by a court for your records. BrightView Health may be required to share that information. BrightView Health will make an effort to discuss with you any instances where your confidentiality may be breached. BrightView Health will make an effort to share only information which is deemed legally necessary.
- Information must be shared with your insurance provider, should you choose to use insurance. This information may be seen by various employees of the insurance provider. There is also potential that certain members of your employer may see this information.

Your Responsibility:

It is also your responsibility to protect the confidentiality of other patients. Do not discuss other patients (names, diagnoses, etc.) outside of group therapy sessions. In order to protect your confidentiality, all patients must agree to honor this policy as well. If you are found to have breached this confidentiality policy, you may be discharged from the program.

By signing this form, you acknowledge that there may be instances where BrightView Health must share your confidential information and you recognize that you are responsible for helping maintain the confidentiality of other patients. Discussing other patients outside of the group sessions may result in your termination from the program.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

COLUMN HEALTH, LLC DBA BRIGHTVIEW HEALTH
NOTICE OF PRIVACY PRACTICES

Effective Date: 1/30/2023
Publication Date: 1/30/2023

Our Privacy Policy

BrightView Health is committed to providing you with quality behavioral healthcare services. An important part of that commitment is protecting your health information according to applicable law. This notice ("Notice of Privacy Practices") describes your rights and our duties under Federal Law. Protected health information ("PHI") 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; the provision of healthcare services; or the past, present or future payment for the provision of healthcare services to you.

Our Duties

We are required by law to maintain the privacy of your PHI, provide you with notice of our legal duties and privacy practices with respect to your PHI, and to notify you following a breach of unsecured PHI related to you. We are required to abide by the terms of this Notice of Privacy Practices. This Notice of Privacy Practices is effective as of the date listed on the first page of this Notice of Privacy Practices. This Notice of Privacy Practices will remain in effect until it is revised. We are required to modify this Notice of Privacy Practices when there are material changes to your rights, our duties, or other practices contained herein.

We reserve the right to change our privacy policy and practices and the terms of this Notice of Privacy Practices, consistent with applicable law and our current business processes, at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. Notification of revisions of this Notice of Privacy Practices will be provided as follows upon request, electronically via our website or via other electronic means, or as posted in our place of business.

In addition to the above, we have a duty to respond to your requests (e.g. those corresponding to your rights) in a timely and appropriate manner. We support and value your right to privacy and are committed to maintaining reasonable and appropriate safeguards for your PHI.

Confidentiality of Substance Use Disorder Patient Records

The confidentiality of substance use disorder patient records maintained by us is also protected by Federal law and regulations. Generally, the law and regulations provide that:

1. We may not disclose to a person outside the treatment center that you are present in the treatment center, that you are a patient of the treatment center, or any information identifying you as having or having had a substance use disorder.
2. Except in specific, limited circumstances described in the federal regulations, we will not disclose any of your substance use disorder patient information to any person outside of the treatment center unless you consent in writing (as discussed below in "Authorization to use or Disclose Confidential Information").

3. Information related to your commission of a crime on the premises of the treatment center or against personnel of the treatment center is *not* protected; and
4. Reports of suspected child abuse and neglect made under state law to appropriate state or local authorities is *not* protected.

See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.

Violation of the federal law and regulations by the treatment center is a crime. Suspected violations may be reported to United States Attorney for the judicial district in which the violation occurs as well as to the Substance Abuse and Mental Health Services (SAMHSA) office responsible for oversight of the treatment center.

Uses and Disclosures

Uses and disclosures of your PHI may be permitted, required, or authorized. The following categories describe various ways that we use and disclose PHI.

Among BrightView Health Personnel: We may use or disclose information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse, provided such communication is (i) within the treatment center; or (ii) between the treatment center and BrightView Health. For example, our staff, including doctors, nurses, and clinicians, will use your PHI to provide your treatment care. Your PHI may be used in connection with billing statements we send you and in connection with tracking charges and credits to your account. Your PHI will be used to check for eligibility for insurance coverage and prepare claims for your insurance company where appropriate. We may use and disclose your PHI to conduct our healthcare business and to perform functions associated with our business activities, including accreditation and licensing.

Secretary of Health and Human Services: We are required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rules.

Business Associates: We may disclose your PHI to Business Associates that are contracted by us to perform services on our behalf which may involve receipt, use or disclose of your PHI. All of our Business Associates must agree to:
(i) protect the privacy of your PHI; (ii) use and disclose the information only for the purposes for which the Business Associate was engaged; (iii) be bound by 42 CFR Part 2; and (iv) if necessary, resist in judicial proceedings any efforts to obtain access to patient records except as permitted by law.

Crimes on premises: We may disclose to law enforcement officers information that is directly related to the commission of a crime on the premises or against our personnel or to a threat to commit such a crime.

Reports of suspected child abuse and neglect: We may disclose information required to report under state law incidents of suspected child abuse and neglect to the appropriate state or local authorities. However, we may not disclose the original patient records, including for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect, without consent.

Court order: We may disclose information required by a court order, provided certain regulatory requirements are met.
Emergency situations: We may disclose information to medical personnel for the purpose of treating you in an emergency.
Research: We may use and disclose your information for research if certain requirements are met, such as approval by an Institutional Review Board.
Audit and Evaluation Activities: We may disclose your information to persons conducting certain audit and evaluation activities, provided the person agrees to certain restrictions on disclosure of information.
Reporting of Death: We may disclose your information related to cause of death to a public health authority that is authorized to receive such information.
Central Registry: By enrolling for Medication Assisted Treatment Services at this facility, your health information may be released to the Central Registry within the State of Massachusetts. I understand that if I do not consent to my information being released to the central registry, my information may be sent to other Opioid Treatment Programs within a 100 mile radius by facsimile to verify dual enrollment.

This information will be viewed by staff at any legally licensed Medication Assisted Treatment facility in the United States when you present and request enrollment and/or emergency medication services. In addition, the above described information could be released to any duly appointed State Opioid Treatment Authority and their staff for the purposes of monitoring dual enrollment verifications.

The above information may be maintained in the LightHouse Software Systems, LLC ("LHSS") central registry system for the purposes of your participation in a Central Registry within the State of Massachusetts, and also for the purpose of aiding your care in times of disaster and preventing multiple opioid treatment program enrollments. LHSS is located at 2120 Placentia Ave, Costa Mesa, CA. The central registry will contain presently prescribed medication(s) used for your treatment and your schedule of dosing records. This information will reside in the LHSS Central Registry while you remain a patient at this treatment facility and will be available to staff where you may present for admission or emergency medication services for up to 60 days after your discharge from treatment at this location. Your name will be encrypted in the LHSS Central Registry system database with technology that meets HIPAA compliance requirements.

Authorization to use or disclose PHI
Other than as stated above, we will not use or disclose your PHI other than with your written authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes or sell your PHI unless you have signed an authorization. If you or your representative authorizes us to use or disclose your PHI, you may revoke that authorization in writing at any time to stop future uses or disclosures. We will honor oral revocations upon authenticating your identity until a written revocation is obtained. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Patient/Client Rights
The following are the rights that you have regarding PHI that we maintain about you. Information regarding how to exercise those rights is also provided. Protecting your PHI is an important part

of the services we provide you. We want to ensure that you have access to your PHI when you need it and that you clearly understand your rights as described below.

Right to Notice
You have the right to adequate notice of the uses and disclosures of your PHI, and our duties and responsibilities regarding same, as provided for herein. You have the right to request both a paper and electronic copy of this Notice. You may ask us to provide a copy of this notice at any time.

Right of Access to Inspect and Copy
You have the right to access, inspect and obtain a copy of your PHI for as long as we maintain it as required by law. This right may be restricted only in certain limited circumstances as dictated by applicable law. All requests for access to your PHI must be made in writing. Under a limited set of circumstances, we may deny your request. Any denial of a request to access will be communicated to you in writing. If you are denied access to your PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by BrightView Health will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the decision made by the designated professional. If you are further denied, you have a right to have a denial reviewed by a licensed third-party healthcare professional (i.e. one not affiliated with us). We will comply with the decision made by the designated professional. We may charge a reasonable, cost-based fee for the copying and/or mailing process of your request. As to PHI which may be maintained in electronic form and format, you may request a copy to which you are otherwise entitled in that electronic form and format if it is readily producible, but if not, then in any readable form and format as we may agree (e.g. PDF). Your request may also include transmittal directions to another individual or entity.

Right to Amend
If you believe the PHI we have about you is incorrect or incomplete, you have the right to request that we amend your PHI for as long as it is maintained by us. The request must be made in writing, and you must provide a reason to support the requested amendment. Under certain circumstances we may deny your request to amend, including but not limited to, when the PHI: 1. was not created by us; 2. is excluded from access and inspection under applicable law; or 3. is accurate and complete. If we deny amendment, we will provide the rationale for denial to you in writing. You may write a statement of disagreement if your request is denied. This statement will be maintained as part of your PHI and will be included with any disclosure. If we accept the amendment, we will work with you to identify other healthcare stakeholders that require notification and provide the notification.

Right to Request an Accounting of Disclosures
We are required to create and maintain an accounting (list) of certain disclosures we make of your PHI. You have the right to request a copy of such an accounting during a time period specified by applicable law prior to the date on which the accounting is requested (up to six years). You must make any request for an accounting in writing.
We are not required by law to record certain types of disclosures (such as disclosures made

pursuant to an authorization signed by you), and a listing of these disclosures will not be provided. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will notify you of the fee to be charged (if any) at the time of the request.

Right to Request Restrictions
You have the right to request restrictions or limitations on how we use and disclose your PHI for treatment, payment and operations. We are not required to agree to restrictions for treatment, payment and healthcare operations except in limited circumstances as described below. This request must be in writing. If we do agree to the restriction, we will comply with restriction going forward, unless you take affirmative steps to revoke it or we believe, in our professional judgment, that an emergency warrants circumventing the restriction in order to provide the appropriate care or unless the use or disclosure is otherwise permitted by law. In rare circum-stances, we reserve the right to terminate a restriction that we have previously agreed to, but only after providing you notice of termination.

Out-of-Pocket Payments
If you have paid out-of-pocket (or in other words, you or someone besides your health plan has paid for your care) in full for a specific item or service, you have the right to request that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or healthcare operations, and we are required by law to honor that request unless affirmatively terminated by you in writing and when the disclosures are not required by law. This request must be made in writing.

Right to Confidential Communications
You have the right to request that we communicate with you about your PHI and health matters by alternative means or alternative locations. Your request must be made in writing and must specify the alternative means or location. We will accommodate all reasonable requests consistent with our duty to ensure that your PHI is appropriately protected.

Right to Notification of a Breach
You have the right to be notified if we (or one of our Business Associates) discover a breach involving unsecured PHI.

Right to Voice Concerns
You have the right to file a complaint in writing with us or with the U.S. Department of Health and Human Services if you believe we have violated your privacy rights. Any complaints to us should be made in writing to our Privacy Official at the address listed below.
We will not retaliate against you for filing a complaint.

Questions, Requests for Information and Complaints
For questions, requests for information, more information about our privacy policy or concerns, please contact us. Our company Privacy Official can be contacted at:

BrightView Health
Attn: Privacy Officer
4600 Montgomery Road, Ste 400
Cincinnati, OH 45212
833.510.4357

We support your right to privacy of your protected health information. You will not be retaliated against in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you believe your rights have been violated and would like to submit a complaint directly to the U.S. Department of Health & Human Services, then you may submit a formal written complaint to the following address:

U.S. Department of Health & Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775
OCRMail@hhs.gov
https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Patient Signed Consent
I fully understand and agree to these policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient Name: _____

Patient/Parent/Guardian Signature: _____

Date: _____

CONSENT FOR ALCOHOL OR DRUG ASSESSMENT AND TREATMENT

Name: _____

DOB: _____

Record #: _____

I understand that as a patient of Column Health, LLC DBA BrightView Health, I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several months.

1. Consent to Evaluate/Treat: I voluntarily consent that I will participate in an alcohol or drug assessment and/or treatment by staff from BrightView Health. I understand that following the assessment and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment
b. Alternative treatment modes and services
c. The manner in which treatment will be administered
d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable)
e. Probable consequences of not receiving treatment

Treatment will be conducted within the boundaries of Massachusetts substance abuse treatment laws. I understand that a range of mental health professionals, some of whom are in training, provides BrightView Health services. All professionals-in-training are supervised by licensed staff.

2. Benefits and Risks to Assessment/Treatment: Assessment and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this assessment include diagnosis, assessment of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations. I understand that while psycho-therapy and/or medication may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. I realize that sometimes medications may have unwanted side effects.

3. Research: As part of ongoing client satisfaction surveys and future research some information from your file may be submitted to third parties or utilized by BrightView Health. Your identifying information will not be shared, however, general information (age, race, and sex) may be shared.

4. Charges: Fees are based on the length or type of the assessment or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

5. **Confidentiality:** Information from my assessment and/or treatment is contained in a confidential medical record at BrightView Health. I understand that BrightView Health will obtain my photograph for the purpose of providing me with a BrightView Health identification card. This same photograph will be stored electronic health records as a primary form of my identification. The purpose of these photos is to be in compliance with BrightView's policy and procedures of using two forms of identification to recognize each client.

I understand surveillance cameras are located throughout BrightView Health for routine observation.

6. **Right to Withdraw Consent:** I have the right to withdraw my consent for assessment and/or treatment at any time by providing a written request to the treating clinician.

7. **General Laboratory Testing and Reporting:** Laboratory testing, including, but not limited to blood work, may be requested. This testing may be to identify diagnosis of HIV, Hepatitis B or C, or other bloodborne disease. Positive results from this lab work must be reported to the appropriate authorities. I authorize BrightView Health to disclose any reportable infectious disease and information regarding that infectious disease to my local and state health department for purposes of coordinating care. Only the minimum amount of protected health information needed to accomplish the intended purpose of the use is permitted for these disclosures. I understand that my alcohol and/or drug abuse treatment records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent. I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will remain valid 90 days after discharge.

8. **Toxicology Testing:** I understand that upon admission and throughout my course of treatment, I will be required to submit to a variety of toxicology tests to include urine drug testing, alcohol testing, pregnancy testing (if applicable), and blood/lab work testing. The treatment team and provider will determine the frequency of these tests. I give my consent to undergo all tests described above as they apply to me. I further give my consent to allow BrightView Health to send my urine specimen to the laboratory for analysis.

9. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

10. **Informed Consent for Medication Assisted Treatment:** In accordance with evidence-based practices, BrightView Health, upon assessment and evaluation and at the recommendation of a physician may prescribe various medications to patients in recovery. These medications are used in conjunction with group counseling, individual counseling, and family counseling. Any medication I receive may have an adverse reaction and/or possible side effects.

The goal of medication assisted treatment is to stabilize functioning. I realize that for some patients' treatment may continue for relatively long periods of time, but that periodic consideration shall be given concerning my complete withdrawal from the use of all drugs.

Treatment with Buprenorphine (if applicable):

Buprenorphine is an FDA approved medication for the treatment of opioid addiction. Buprenorphine can be used for detoxification or for maintenance therapy. Maintenance therapy can continue as long as medically necessary. There are other treatments for opiate addiction, including methadone, naltrexone, and some treatments without medications. The appropriate treatment plan for you will be determined by your primary counselor and a physician.

Use of buprenorphine will maintain your physical dependence. If you discontinue it suddenly, you will likely experience withdrawal. If you are not already dependent, you should not take buprenorphine as it could eventually cause physical dependence. The medication you will be taking will likely contain both buprenorphine and an opiate blocker (naloxone). If the medication is abused by snorting or injection, the naloxone will cause severe withdrawal but when taken as directed, the naloxone has no effect.

If you are dependent on opioids **you should be in as much withdrawal as possible when you take the first dose of buprenorphine/ naloxone. If you are not in withdrawal, buprenorphine/ naloxone can cause severe opiate withdrawal.** We recommend that you arrange not to drive after your first dose, because some patients may experience drowsiness during the early phases of treatment. It may take several days to feel completely comfortable with the transition to buprenorphine/naloxone.

Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) has resulted in deaths. Although sublingual buprenorphine has not been shown to be liver-damaging, your doctor will monitor your liver tests while you are taking buprenorphine. (This is a blood test.) Attempts to override the buprenorphine by taking more opioids could result in an opioid overdose. You should not take any other medication without discussing it with the physician first.

I understand that buprenorphine products and other medication assisted treatment medications may interact with other prescription medications, vitamins and nutritional supplements. Potential interactions include increasing or decreasing the level of buprenorphine products in my body or, in extremely rare instances, possibly causing an abnormal heart rhythm that has the potential to be lethal. I agree that it is my responsibility to provide documentation of all medication, vitamins and nutritional supplements I am taking on at least a monthly basis.

I understand that I may withdraw from this treatment and discontinue when indicated the use of the medication at any time, and I shall be afforded medical withdrawal under medical supervision. The medically supervised withdrawal could be either a short-term withdrawal or long-term withdrawal. This will be at the discretion of the Medical Director/Provider. I understand that once I complete a medically supervised withdrawal, I may be offered an aftercare program which will include counseling only.

FOR EKG/ECG TESTING (if applicable): An electrocardiogram (sometimes called EKG or ECG) is a noninvasive procedure to obtain a graphical presentation of the heart's electrical activity derived by amplification of the minutely small electrical impulse normally generally by the heart. The tracing is obtained using 10 electrodes placed on the skin of the chest, arms, and legs. If any artifact (like static) occurs, some electrodes may need to be repositioned to ensure a clear recording of the heart. This test is used to identify and diagnose several different heart conditions. Risks include possible redness and itching at the sites of the electrode placement and possible minor skin irritation.

FOR WOMEN WHO ARE OR MAY BECOME PREGNANT: While methadone is approved by the FDA for medication-assisted treatment for opioid addiction in pregnant patients, there are no conclusive data regarding the safety of methadone in human pregnancy and it may be harmful to unborn babies. Tell your doctor and the Program's Medical Director/Provider if you are pregnant or plan to become pregnant. After delivery, babies may experience withdrawal symptoms. A small amount of methadone is transmitted through breast-milk; therefore, discuss breastfeeding with your doctor.

Understanding the risks and benefits associated with methadone maintenance therapy, as well as alternatives to it, I hereby give my informed and voluntary consent to receive methadone maintenance therapy from BrightView Health.

11. Opiate Treatment Program (OTP) (if applicable)

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a substance use disorder treatment program, since the use of other medications in conjunction with medication assisted treatment prescribed by the treatment program may cause me harm. In addition, I agree that I am not currently enrolled in another OTP at this time.

I understand State and Federal law prohibits dual enrollment in opiate treatment programs. I therefore give my consent to allow BrightView Health to disclose my enrollment status, via fax or verbal confirmation, to all opiate treatment programs in accordance with state and federal law guidelines. I further give my consent to allow BrightView Health to disclose my enrollment status, via fax, electronic transfer or verbal confirmation, to a statewide Central Registry in accordance with State and Federal law as well as any other OTP within a 100-mile radius.

I hereby certify that no guarantee or assurance has been made as to the results that may be obtained from alcohol and drug treatment. With full knowledge of the potential benefits and possible risks involved, I consent to assessment and treatment.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

CONSENT FOR MENTAL HEALTH TREATMENT

Name: _____

DOB: _____

Record #: _____

Column Health LLC DBA BrightView Health provides a broad range of outpatient mental health services. Mental health services may include but are not limited to medication management, psychotherapy, and counseling. It is a collaborative process between you, medical providers, and your therapist. Our medical providers and therapists have been trained in a variety of treatment methods and will determine which approaches and techniques would most benefit you. The type and extent of services that you will receive are determined following an initial assessment and thorough discussion between you and your medical providers and therapist. The results of mental health therapy cannot be guaranteed, and you may terminate therapy at any time. If a therapist or provider at BrightView Health is not able to provide the treatment necessary to address a particular concern, behavior, or diagnosis, BrightView Health will make a referral to an appropriate provider in order to best meet your needs.

1. Consent to Evaluate/Treat: I voluntarily consent that I will participate in outpatient mental health treatment by staff from BrightView Health. I understand that following the assessment and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment
b. Alternative treatment modes and services
c. The manner in which treatment will be administered
d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable)
e. Probable consequences of not receiving treatment

Treatment will be conducted within the boundaries of Massachusetts mental health treatment laws. I understand that a range of mental health professionals, some of whom are in training, provide BrightView Health services. All professionals-in-training are supervised by licensed staff.

2. Benefits and Risks to Assessment/Treatment: Assessment and treatment may be administered with psychological interviews, psychological assessment or testing, and psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this assessment include diagnosis, assessment of prior treatment, estimating prognosis, and education. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations. I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. I realize that sometimes medications may have unwanted side effects.

3. Research: As part of ongoing client satisfaction surveys and future research some information from your file may be submitted to third parties or utilized by BrightView Health. Your identifying information will not be shared, however, general information (age, race, and sex) may be shared.

4. Charges: Fees are based on the length or type of the assessment or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

5. Confidentiality: Information from my assessment and/or treatment is contained in a confidential medical record at BrightView Health. I understand that BrightView Health will obtain my photograph for the purpose of providing me with a BrightView Health identification card. This same photograph will be stored electronic health records as a primary form of my identification. The purpose of these photos is to be in compliance with BrightView Health's policy and procedures of using two forms of identification to recognize each client. I understand surveillance cameras are located throughout BrightView health for routine observation.

6. Right to Withdraw Consent: I have the right to withdraw my consent for assessment and/or treatment at any time by providing a written request to the treating clinician.

Printed Name of Client _____

Signature of Client _____ Date _____

MEDICATION ADHERENCE AT BRIGHTVIEW HEALTH

Medication adherence simply means sticking to the medication prescribed/ordered for you. Adhering to medication is also taking the medication as directed by a health care professional - whether taken in pill form, inhaled, injected, or applied topically.

Not taking medication as prescribed is called non-adherence. Many people never fill their medications, or they may never pick up their filled prescriptions from the pharmacy. Other people bring their medication home, but don't follow their health care professional's instructions - they skip doses or stop taking the medicine.

Specifically, non-adherence includes:

- Not filling a new medication or refilling an existing medication when you are supposed to
- Stopping a medicine before the instructions say you should
- Taking more or less of the prescribed/ordered medicine; or at the wrong time of day

Often there is no single reason someone does not take their medicine as directed, but rather a combination of reasons. One person may face different barriers at different times as he or she manages his or her condition. Whatever the reason, the result is always the same - patients miss out on life -saving benefits, a better quality of life, and lose protection against future illness or serious health complications.

All medicines have risks and benefits. When a patient works with their health care professional to decide to use medicine to help manage a long-term health condition, he or she accepts certain risks in exchange for potential health benefits. Consumers can help manage those risks by using medicines safely, including storing & disposing of them safely.

Importance of Medication Adherence Specifically at BrightView Health

Some of the medications prescribed at BrightView Health are controlled substances which have an increased requirement for compliance from patients. This is very important because of the health and possible legal consequences associated.

- All patients must take medication EXACTLY as prescribed/ordered.
    - o Do not attempt to adjust the dose of your medication up or down without consultation of your physician.
- Keep medications in a safe and secure location.
    - o Theft of medication will not result in an early refill.
- If you have any questions concerning medication, set up an appointment with the nurse practitioner/physician.
- Because of the medication you are taking and a history of substance abuse, it is vital that you coordinate your other medical appointments or surgical/dental procedures that you have with BrightView Health. Plan ahead.
- It is important that you tell your primary care physician or any other physician who writes a prescription that you are receiving treatment services at BrightView Health.
- DO NOT EVER SELL YOUR MEDICATION OR TRY TO BUY M EDICATION FROM SOMEONE. THIS WILL LIKELY RESULT IN IMMEDIATE DISMISSAL FROM THE PROGRAM AND CAN RESULT IN LEGAL CONSEQUENCES FOR YOU AS A PATIENT.
- NON-ADHERENCE WITH YOUR MEDICATION REGIMEN CAN ALSO RESULT IN RESTRICTIONS BY YOUR INSURANCE COMPANY THAT CANNOT BE RESOLVED BY THE TEAM AT BRIGHTVIEW HEALTH. YOU MAY LOSE THE ABILITY TO GET YOUR MEDICATIONS PAID FOR BY INSURANCE.
- **BRING ALL MEDICATIONS PRESCRIBED BY BRIGHTVIEW HEALTH PROVIDERS TO EVERY MEDICAL APPOINTMENT.**

Patient: _____ Date: _____

Dear Patient,

Welcome to BrightView Health. We appreciate the opportunity to be of service to you. Our office is dedicated to excellence in patient care. To maintain our high standards, we believe that it is important that we communicate our policies to you. Please take a moment to read and become familiar with these policies. Should you have any questions, the office staff is happy to help answer them. By presenting these policies in advance, we can avoid any surprises or misunderstandings. We appreciate your time and your understanding.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

• **Payment Responsibility:** I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment or co-payment is due at the time services are rendered unless special arrangements have been made. It is my responsibility to confirm coverage is provided by my insurance company or other provider.

• **Charges for Additional Services:** I understand that charges will be added to my account for other professional services rendered. These charges will be in increments of 15 minutes, or by encounter, and BrightView Health will always discuss additional charges with me. Other professional services include extended contact via email, consulting with other professionals (with my permission), preparation of records or treatment summaries, and the time spent performing any other service I may request.

• **Appointments & Cancellations:** I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members. Repeated missed appointments may result in termination of therapy. There may be a time when my therapist or physician may need to cancel my appointment for an emergency; BrightView Health will make every effort to reschedule me/my family in an appropriate time frame. This will be at no charge to me.

I fully understand and agree to these policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient Name: _____
Last First Middle Initial

Patient/Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

TREATMENT CONTRACT

I, _____ , understand that the goal of Medication-Assisted Treatment (MAT) is to suppress my withdrawal symptoms and cravings for my drug of choice. This assistance should allow me to regain a normal state of mind so that I can focus my efforts on making changes in my thoughts, behaviors and environment to better support my recovery. I understand that BrightView's plan may include tapering me completely off medication during the final phase of treatment.

WHAT I MUST DO TO REMAIN IN BRIGHTVIEW HEALTH RECOVERY:

1. I agree to work with my treatment team to create an individualized treatment plan and abide by the recommendations of the medical and clinical providers.
2. I agree to keep and be on time to all my appointments. If I miss my scheduled appointment, I must call within 24 hours to reschedule.
3. I agree to conduct myself in a courteous manner on BrightView Health property and not to conduct any illegal or disruptive activities on BrightView Health property.
4. I agree to respect and protect the confidentially of others regarding the presence and disclosures of all patients.
5. I agree to complete the entire program which has been recommended by my treatment providers.
6. I agree to accept referral to a higher level of care (i.e. residential or inpatient) if recommended.
7. I agree to abstain from all non-prescribed medications, alcohol, opioids, cocaine, and other addictive substances [except nicotine].
8. I agree to maintain a safe and sober living environment at all times.
9. I understand that if I engage in highly dangerous behavior, such as abusing benzodiazepine, a sedative or sleeping medication, or I consume a heavy amount of alcohol while on MAT medication that I may be promptly referred to a higher level of care (hospital or residential) and no further medication will be prescribed to me.
10. I agree to provide a urine sample for drug testing at intake, every day that I have appointments, and as requested thereafter and to have my blood alcohol level tested.
11. I agree to take my medications exactly as prescribed. I understand that adjusting my own dosage may result in discharge from the program.
12. I agree to keep my medication in a locked, safe, and secure location in my home and out of the reach of children and others at all times.
13. I agree to disclose the names of all doctors and dentists who have prescribed a controlled substance (an opioid, benzodiazepine or amphetamine/stimulant) to me in the past year and sign a release of information form so that a BrightView Health physician can coordinate my care with that, or those, prescribers.
14. I agree to inform all doctors, dentists and hospitals that treat me while I am in the BrightView Health MAT program that I am prescribed MAT medication and sign a release of information form so that a BrightView Health physician can coordinate my care with that, or those, providers.

CAUSES FOR DISMISSAL

1. I understand that I may be discharged if I engage in any of the following unacceptable behaviors:
2. If I use any rude, profane, or threatening language with any BrightView Health staff member at any time.
3. If I provide any false or misleading information about my identity, my criminal history, or any reporting requirements for probation, parole or Children's Protective Services (CPS).
4. If I provide any false or misleading information about my medical history, any prior treatment for substance abuse including the prescribing of Buprenorphine or methadone, or any false information regarding the use or prescribing of benzodiazepines (Xanax, Valium, Librium, Serax, Klonopin etc.)
5. I attempt to give, buy, or sell medication or drugs to any other person.
6. I attempt to alter or falsify a prescription, or a urine drug specimen.

7. I refuse to provide a urine drug specimen or come in for a medication count when requested.
8. My urine does not show the expected presence of MAT medication or other medication prescribed by BrightView Health.
9. If I fail to tell a doctor or dentist that I am on MAT medication or other medication and I attempt to obtain or obtain a controlled substance from that doctor or dentist.
10. If I fail to promptly inform BrightView Health staff that I have been prescribed a controlled substance by another doctor, dentist, hospital, urgent care or emergency department.
11. I miss a scheduled detoxification/induction appointment.
12. I fail to attend a scheduled case review.
13. I fail to make satisfactory payment arrangements for an outstanding balance of $500 (five hundred dollars) or more which is more than 30 days past due.
14. Need to leave program for a medical or other mental health issue (Suspension to be determined by the Medical Director)

DISCHARGE FROM THE PROGRAM

I understand that once dismissed from the program, there may be a period before I can re-engage in services. Even after this designated period, reinstatement into the treatment program is not guaranteed. Reinstatement is at the sole discretion of the Medical Director and/or the patient's clinical treatment team. If I am discharged, a final prescription or medications will be released at the discretion of the medical team/director. A final prescription/medication is not guaranteed.

I understand that BrightView Health may discharge me prior to completion of treatment:

1. If I violate any of the above items or engage in any of the unacceptable behaviors described in the above section.
2. If I have persistently not complied with my attendance requirements, treatment recommendations, or met my financial obligations to BrightView Health as I agreed to do this in the treatment contract.
3. If I have been referred to a higher level of care (residential or hospital) but refuse to go.
4. Need to leave program for a medical or other mental health issue
5. If I request a voluntary discharge.

I understand that discharge from treatment at BrightView Health is a decision made by the entire treatment team and not any single member of the team. The rationale for this is to ensure that my treatment team utilizes multiple strategies to engage with me before discharge occurs.

ACKNOWLEDGMENT:

The staff at BrightView Health has reviewed each of the items contained in this Treatment Contract with me. I believe these terms and requirements are reasonable. I understand that they are meant to help support me in my recovery, and I agree to them all and agree to abide by all guidelines.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

ALCOHOL & DRUG SCREENS AND PHLEBOTOMY SERVICES

It is the policy of BrightView Health to perform alcohol & drug screens on all patients via urinalysis. Patients will be screened at intake as well as periodically and randomly throughout treatment. A positive alcohol and/or drug screen is not cause for immediate termination from the program. However, a positive alcohol and/or drug screen could result in a change in a patient's treatment plan. In some cases, urine specimens may be sent to outside laboratories for screening. If a specimen is sent to an outside laboratory and results in a positive screening, the positive result will be reviewed by BrightView Health staff with the patient. Alcohol and/or drug screens may not be covered by an insurance provider. If this is the case, the patient will be responsible for payment for the alcohol and/or drug screen.

Refusal to consent to an alcohol or drug screen will be recorded as a "positive" result in the patient record. Repeated positive alcohol and/or drug screens can result in a change in treatment plan and/ or termination from the program.

CONSENT FOR ALCOHOL & DRUG SCREENS

By signing below, I am giving BrightView Health and any/all approved employees of BrightView Health permission to take a urine and/or saliva sample from me for evidence of alcohol and drug use. The purpose of obtaining the specimen is to monitor the possible use of illegal substances. I also understand that to maintain the integrity of the specimen I may be observed by a BrightView Health staff member while the urine specimens are obtained. However, I will be afforded a reasonable amount of privacy and will not be required nor allowed to expose my genitals at any time.

PHLEBOTOMY SERVICES

We may perform blood draws on the following during induction and routinely thereafter:

- Comprehensive Metabolic Panel
- Complete Blood Count w/ diff/plt
- Thyroid Cascade
- Hepatic Function
- HIV ½ antigen/antibody, 4th gen w/ reflex
- Hepatitis C ab w/ reflex to HCV RNA, qn, PCR

Patient Signature: _____ Date: _____

Testing is performed by a third party vendor. While most of these tests are covered by insurance, self-pay patients may receive a bill from a third party vendor.

CONSENT TO MASSACHUSETTS CENTRAL REGISTRY
42 CFR Part 2 and HIPAA

I have been informed and understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Therefore I, _____, authorize
[Patient's Name]

Column Health, LLC doing business as BrightView Health to disclose the following
[name of OTP]

to the Massachusetts Central Registry operated by LightHouse Software Systems located at 17352 Derian Avenue, Irvine, CA on behalf of the Massachusetts Department of Public Health/Bureau of Substance Addiction Services (BSAS). The Massachusetts Central Registry will contain presently ordered medication(s) used for my Medication for Opioid Use Disorder treatment. The purposes of this disclosure are to prevent an interruption in my treatment and/or care and to prevent multiple simultaneous medications for opioid use disorder treatment enrollments as well as complying with State and Federal reporting requirements.

This information will reside in the Massachusetts Central Registry system while I remain a patient at this clinic and will be available to staff where I may present for admission or courtesy dosing as well as to BSAS as required by law. My name will be encrypted in the Massachusetts Central Registry System database with technology that will meet HIPAA compliance requirements and the information will be shared via secured electronic transmission. The information will be available to providers for 60 days post-discharge for enrollment verification purposes. A copy of the record will be maintained in the Massachusetts Central Registry System.

I understand that this information will be viewed by staff at any Massachusetts certified Opioid Treatment Program when I present and request enrollment, including opioid treatment programs that open in the future, as well as any other opioid treatment programs in states that participate in the Central Registry System operated by Light House. All states are subject to Federal privacy laws including but not limited to HIPAA and 42 CFR Part 2.

Patient information: First name, last name, middle initial, last four digits of SSN, gender, birth date, patient ID, photographic image, patient contact information

Demographics: Race, ethnicity, education, employment

Housing status: City/County/State/Zip Code, Zip Code (if Homeless), Distance traveled to treatment

Referral: Counselor

Substance use and treatment history: primary substance of misuse, primary route of administration, secondary substance of misuse, secondary route of administration

Current treatment: Medication for Opioid Use Disorder SUD Medication Type, Medication for Opioid Use Disorder SUD Medication Form, Method Route of Administration, ,SUD Medication Dosage Medication for Opioid Use Disorder, SUD Medication Issued Through Date, take-home level, attendance days, type of treatment

Pregnancy Status

Discharge Information: Date of discharge, discharge reason, dosed through (date), medication, dosage, take-home level at discharge, education, employment status, housing at discharge

Patient Agreement /Statement

Please Initial:

_____ I understand my records are protected under the Federal Confidentiality Regulations and may not be disclosed without my express written consent unless otherwise provided for by law. I also understand I may revoke this consent at any time except to the extent that action has been taken in accordance with it, and in any event, this consent expires automatically as set forth below.

_____ I understand when any clinic which participates in the Central Registry requests information from the Central Registry and I am found to be enrolled in another clinic, the Central Registry will disclose the name, address, telephone number, and most recent dosing history of the clinic in which I am already enrolled to the requesting clinic.

_____ I understand I may view and request a copy of the information described above and/or in this form.

_____ I understand that a copy of this form will be made a part of my medical record.

_____I approve my mobile phone number to be used by the Central Registry to text information to me about my clinic's emergency closures due to natural and man-made disasters, closure/disaster information updates, program reminders and notifications from the Department of Public Health, Bureau of Substance Addiction Services (BSAS).

_____ I approve my email address to be used by the Central Registry to email information to me about my clinic's emergency closures due to natural and man-made disasters, closure/disaster information updates, program reminders and notifications from the Department of Public Health / Bureau of Substance Addiction Services.

_____I am not receiving medication for opioid use disorder treatment from another Opioid Treatment Program, its medication unit / mobile opioid treatment program, or an Office-Based Opioid Treatment provider.

_____I have been provided a copy of this form.

_____I have declined a copy of this form (including an E-Copy).

This form is invalid after 60 days post-discharge.

_____
Patient Signature

_____
Date

Massachusetts Central Registry Emergency Closure Notification Authorization

I, _____, herby give authorization for Lighthouse Software Systems* on the behalf of the Massachusetts Central Registry to notify me in the event my treatment facility is closed due to a disaster or other event that would limit my access to Medication for Opioid Use Disorder (MOUD) services. The notification will come via email and/or cellular text message, based on the information I have provided to my treatment center. The message will state:

Subject: 911 Emergency Closure Notification
Message: Name of the treatment center, closure date, closure time and expected re-opening date (if possible).

I understand the message will not include any information that will identify me as a patient of the treatment center or include any medication information. I understand that I can decline to have the Central Registry to notify me without having any negative impact on my treatment. I further understand that this authorization may be revoked at any time I choose without having any impact on my treatment.

My Current Cell Phone Number: _____

My Current Email Address: _____

Signed: _____
Date: _____

Witness: _____
Date: _____

Patient Declines to Use of Photographic Image:

_____Patient Agrees to Participate in the Central Registry but does not agree to provide photographic image.

Patient Declination Statement:

____ Patient Declines to Participate in Massachusetts Central Registry System.

I understand that as a patient of __BrightView Health_ , I will not receive any emergency/disaster services from the Massachusetts Central Registry System.

_____
Patient Signature

_____
Date

*Lighthouse Software Systems, LLC is located at 17352 Derian Ave., Irvine, CA 92614

CONSENT TO PHOTOGRAPH

It is the policy of BrightView to photograph each patient for the purpose of identification during treatment. This photograph becomes a confidential component of the permanent record. I, the undersigned, do hereby authorize staff members of BrightView to photograph me while under their care.

Patient Name (Print) Date

Patient Signature Date

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS

As a patient of BrightView Health, it is important that we be able to contact your using your wireless telephone or email to remind you of appointments, to obtain your feedback on your experience with our healthcare team, to obtain feedback for marketing purposes and to provide you with advertisements or telemarketing messages. We may use an automatic telephone dialing system or an artificial or pre- recorded voice to deliver these messages to you.

By entering your wireless telephone number or email below, you authorize Column Health, LLC DBA BrightView Health, its employees and its agents, to send emails or text messages, and make telephone calls to that number. You agree that we may use your wireless telephone number or email address to send you information, including healthcare information, advertisements and telemarketing messages. You also understand that we may use an automatic telephone dialing system or an artificial or pre-recorded voice to deliver these messages to your wireless telephone number.

Column Health, LLC DBA BrightView Health does not charge for these services, but regular text messaging or incoming call rates may apply. Contact your carrier for pricing plans and details.

You are not required to provide this consent in order to receive services from BrightView Health.

You may revoke this consent at any time by providing us with notice that you no longer want to receive these communications via your wireless telephone, or by replying "STOP" to any text message or email you receive from us.

You consent to receiving these communications at the following wireless telephone number:

_____

You consent to receiving these communications at the following email address:

_____

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

BrightView

Consent for the Release of Information under 42 C.F.R. PART 2 Confidentiality of Substance Use Disorder Patient Records

I, _____ authorize _____
(Name of patient) (Name of provider)

Information to be disclosed I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. I authorize the release or disclosure of the substance use disorder records below:

☐ All my substance use disorder records;

or only the following specific types of records:

☐ Toxicology Results ☐ Medication(s)/dosing ☐ Assessments Treatment plan
☐ Lab results ☐ Appointments ☐ Diagnostic information
☐ Discharge Summary ☐ Substance Use History ☐ Trauma History Summary
☐ Progress in Treatment Insurance ☐ info/demographics

To: _____
(Name of person or organization to which disclosure is to be made)

Phone: _____ Fax: _____

For (purpose of disclosure): administration ☐ Continuity of Care ☐ Coordinating Treatment
☐ Emergency Contact ☐ Payment/Benefits

☐ Other: _____

I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I also understand that, to the extent my patient records contain patient records from my other providers, those records cannot be re-disclosed without my express written consent which I am granting by signing this form. I do not need to sign this form to obtain treatment. I understand Insurance payment, enrollment or eligibility maybe affected if I do not sign. I understand I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate either :

☐ in one year from the date of signature OR 90 days after discharge (whichever comes first); **OR upon a specific**
☐ **date, event, or condition as listed here:** _____
(Specific date, event or condition)

Patient's Signature: _____ Date: _____
If the patient is a minor, only the minor can sign this consent.

_____ _____ _____
Print Name Date of Birth (MM/DD/YY) Medical Record Number

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: _____

Print: _____

Legal Authority: _____ Date: _____

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Patient Revocation: _____ Date: _____

NOTICE TO RECIPIENT OF INFORMATION
42 CFR part 2 prohibits unauthorized disclosure of these records.

BrightView

Consent for the Release of Information under 42 C.F.R. PART 2 Confidentiality of Substance Use Disorder Patient Records

I, _____ authorize Column Health LLC, DBA BrightView Health

(Name of patient) (Name of provider)

Information to be disclosed I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. I authorize the release or disclosure of the substance use disorder records below:

☒ All my substance use disorder records;

or only the following specific types of records:

☐ Toxicology Results	☐ Medication(s)/dosing	☐ Assessments Treatment plan
☐ Lab results	☐ Appointments	☐ Diagnostic information
☐ Discharge Summary	☐ Substance Use History	☐ Trauma History Summary
☐ Progress in Treatment Insurance		☐ info/demographics

To: Beacon Health Strategies

(Name of person or organization to which disclosure is to be made)

Phone: 1-877-868-0312 Fax: _____

For (purpose of disclosure): administration ☒ Continuity of Care ☒ Coordinating Treatment ☐ Emergency Contact ☒ Payment/Benefits

☐ Other: _____

I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I also understand that, to the extent my patient records contain patient records from my other providers, those records cannot be re-disclosed without my express written consent which I am granting by signing this form. I do not need to sign this form to obtain treatment. I understand Insurance payment, enrollment or eligibility maybe affected if I do not sign. I understand I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate either :

☐ in one year from the date of signature OR 90 days after discharge (whichever comes first); **OR upon a specific**
☐ **date, event, or condition as listed here:** _____

(Specific date, event or condition)

Patient's Signature: _____ Date: _____

If the patient is a minor, only the minor can sign this consent.

_____ _____ _____

Print Name Date of Birth (MM/DD/YY) Medical Record Number

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: _____

Print: _____

Legal Authority: _____ Date: _____

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Patient Revocation: _____ Date: _____

NOTICE TO RECIPIENT OF INFORMATION

42 CFR part 2 prohibits unauthorized disclosure of these records.

BrightView

Consent for the Release of Information under 42 C.F.R. PART 2 Confidentiality of Substance Use Disorder Patient Records

I, _____ authorize Beacon Health Strategies

(Name of patient) (Name of provider)

Information to be disclosed I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health and substance use. I authorize the release or disclosure of the substance use disorder records below:

☐ All my substance use disorder records;

or only the following specific types of records:

☐ Toxicology Results ☐ Medication(s)/dosing ☐ Assessments Treatment plan ☒ All Claims and Related History

☐ Lab results ☐ Appointments ☐ Diagnostic information

☐ Discharge Summary ☐ Substance Use History ☐ Trauma History Summary

☐ Progress in Treatment Insurance ☐ info/demographics

To: Column Health LLC, DBA BrightView Health

(Name of person or organization to which disclosure is to be made)

Phone: 617-539-6780 Fax: 339-368-7649

For (purpose of disclosure): administration ☑ Continuity of Care ☑ Coordinating Treatment

☐ Emergency Contact ☑ Payment/Benefits

☐ Other: _____

I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R. Part 2 - Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I also understand that, to the extent my patient records contain patient records from my other providers, those records cannot be re-disclosed without my express written consent which I am granting by signing this form. I do not need to sign this form to obtain treatment. I understand Insurance payment, enrollment or eligibility maybe affected if I do not sign. I understand I may revoke this consent in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate either :

☐ in one year from the date of signature OR 90 days after discharge (whichever comes first); **OR upon a specific**

☐ **date, event, or condition as listed here:** _____

(Specific date, event or condition)

Patient's Signature: _____ Date: _____

If the patient is a minor, only the minor can sign this consent.

_____ _____ _____

Print Name Date of Birth (MM/DD/YY) Medical Record Number

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: _____

Print: _____

Legal Authority: _____ Date: _____

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Patient Revocation: _____ Date: _____

NOTICE TO RECIPIENT OF INFORMATION

42 CFR part 2 prohibits unauthorized disclosure of these records.

BRIGHTVIEW HEALTH INFORMED CONSENT - TELEMEDICINE SERVICES

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care.

Providers may include practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, treatment, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and medical data and will include measures to safeguard data to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in a clinical setting (or at a remote site) while the practitioner obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

Clinical Considerations:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Security considerations:

- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

Confidentiality considerations:

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My practitioner has explained the alternatives to my satisfaction.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
5. I understand that it is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my practitioner or other treatment providers as designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Patient Name Printed: _____

Patient Signature: _____

Date: _____