DISCLOSURE STATEMENT

Client Name: _____ DOB: _____ Age:_____

STATEMENT OF FEES:

Insurance billed services: Individual Therapy: $150 per session, Family Therapy: $200 per session. Group therapy: $100 per session.

Open Path Collective clients: Please provide confirmation of your enrollment. Fees are determined on a case by case basis.

I, _____have reviewed Emerald Behavioral Health's fees and I am aware that they are subject to a sliding scale as negotiated if applicable.

Please read each item carefully and initial:

_____I understand that my private insurance will be billed for the therapy services at the rates listed above and that any cash paying clients will have rates negotiated at a sliding scale according to need.

_____I understand Emerald Behavioral Health accepts some insurance for eligible services.

_____ I understand that it is my responsibility to ensure services are covered by my insurance prior to onset.

_____I understand that the fees and terms of this statement can be changed with 30 days' notice.

_____I understand that payment/copay is due at the start of session for all clients.

My signature below attests to my having read and understood the information with my agreement to the terms and conditions outlined above.

Client/Parent/Guardian:_____ Date: _____

Client/Parent/Guardian:_____ Date: _____

Staff signature: _____Date: _____

SERVICE AGREEMENT

Client Name: _____ DOB: _____ Age:_____

Emerald Behavioral health therapeutic services:

1. I agree to participate to the best of my ability and to follow through with recommendations.

2. I will promptly report any changes in my living situation, address, and phone number.

3. My dress will be appropriate and will not include revealing or seductive themes and will not promote substance use or self-harm or harm to others.

4. Foul and offensive language, violence, or any other abuse is prohibited.

5. I understand that Emerald Behavioral Health and other occupants of the facility are not responsible for any belongings that I may leave on the premises.

6. I understand that tobacco use is not allowed on any premises in which services are held.

7. I agree to keep confidential all information regarding persons participating in services.

8. I understand that my data may be collected through intakes, questionnaires, assessments, and attendance records for research purposes with the understanding that all identifiers will be removed to ensure confidentiality.

9. I understand that there will be a surveillance system installed in the facility, without audio enabled, for the sole purpose of security and no individuals will have their privacy hindered in any way.

- _____ I acknowledge by my initials that I agree to the expectations listed above.

Discontinuation of Services:

- _____ I understand that the following will be cause to consider for immediate discharge: 1. Any physical violence or threat to individuals on the premises 2. Possession of weapons, alcohol, drugs or paraphernalia, while on the premises. 3. Use of any mood-altering substances, including alcohol, while on the premises.

Client/Parent/Guardian:_____ Date: _____

Client/Parent/Guardian:_____ Date: _____

Staff signature: _____Date: _____

CONSENT FOR TREATMENT

1. My participation in therapy services is voluntary and I agree to participate. I understand that I can end treatment at any time.

2. I understand that my behavioral health provider may make recommendations that I don't agree with (e.g. modality of treatment, duration of treatment, frequency of visits, etc.).

3. I understand that Emerald Behavioral Health cannot guarantee results (e.g. reduction in symptoms, improved relationships, reunification of family, etc.).

4. I understand that there may be some risks in participation in behavioral health services. I am aware that I can discuss any unforeseen risks vs. benefits with my behavioral health provider at any time. These may include but are not limited to: A. Addressing painful emotional experiences and/or feelings; B. Gaining new awareness and or perspective on a particular issue; C. Being inconvenienced due to costs/fees of service.

I have reviewed this information. I have been given the opportunity to ask questions about this information. A copy of this information is available upon request. By signing this, I indicate my understanding of this information.

Client/Parent/Guardian:_____ Date: _____

Client/Parent/Guardian:_____ Date: _____

Staff signature: _____Date: _____

INDIVIDUAL RIGHTS AND RESPONSIBILITIES

Parent or legal guardian must provide consent for outpatient services to minors age 13 years of age or younger. Minors 14 years of age or older may provide informed consent for outpatient services independent of parental or guardian consent.

In addition to all applicable statutory and constitutional rights, every individual receiving services has the right to: Be treated with dignity and respect; Have all services explained, including expected outcomes and possible risks; Confidentiality, and the right to consent to disclosure in accordance with ORS 107.154, ORS 179.505, ORS 179.507, ; ORS 192.215. ORS 192.507. 42 CFR Part 2 and 45 CFR Part 205.50. Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law. Minor children may give informed consent to services in the following circumstances: Under age 18 and lawfully married' Age 16 or older and legally emancipated by the court; or Age 14 or older for outpatient services only. For purposed of informed consent, outpatient service does not include service provided in residential programs or in day or partial hospitalization programs; Inspect their Individual Service Record in accordance with ORS 179.505; Not participate in experimentation; Receive prior notice of service conclusion or transfer, unless the circumstanced necessitation service conclusion or transfer pose a threat to health and safety; Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation; Have religious freedom; Be free from seclusion and restraint, except as regulated in OAR 309-032-1540(9). Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule; Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented; Have involvement in service planning and delivery; Make a declaration for mental health treatment, when legally an adult; File grievances, including appealing decisions resulting from the grievance; Exercise all rights set forth in ORS 109.610 through 109.697 if the individual is a child, as defined by these rules; Exercise all rights set forth or ORS 426.385 if the individual is committed to DHS; and Exercise all rights described in this rule without any form of reprisal or punishment.

In addition to the individual rights, every individual receiving services has the right to: A safe, secure and sanitary treatment environment; A humane service environment that affords reasonable protection from harm, reasonable privacy and daily access to fresh air and the outdoors; Keep and use personal clothing and belongings, and to have an adequate amount of private, secure storage space. Reasonable restriction of the time and place of use, of certain classes of property may be implemented if necessary to prevent the individual or others from harm, provided that notice of this restriction is given to individuals and their families, if applicable, upon entry to the program, document, and reviewed periodically; Express sexual orientation, gender identity and gender presentation; Have access to participate in social, religious and community activities; Private and uncensored communications by mail, telephone and visitation, subject to the following restrictions:

This right may be restricted only if the provider documents in the individual's record that there is a court order to the contrary, or that in the absence of this restriction, significant physical or clinical harm will result to the individual or others. The nature of the harm must be specified in reasonable detail, and any restriction of the right to communicate must be no broader than necessary to prevent this harm; and The individual and his or her guardian, if applicable, must be given specific written notice of each

restriction of the individual's right to private and uncensored communication. The provider must ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible and allow for confidential communication, and that space is available for visits. Reasonable times for the use of telephones and visits may be established in writing by the provider;

Communicate privately with the public or private rights protection programs or rights advocates, clergy, and legal or medical professionals; Participate regularly in indoor and outdoor recreation;

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed by Emerald Behavioral Health and how you can get access to this information. Please review it carefully. Emerald Behavioral Health is required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is 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 will not use or discloses PHI about you without your written authorization, except as described in this Notice. We reserve the right to change this notice and our practices, effective immediately on all PHI we maintain. Upon request, we will provide any revised Notice to you. Your Health Information Right: (You have the following rights with respect to PHI) You have the right to request additional restriction by sending a written request to Emerald Behavioral Health that maintains your clinical records. Emerald Behavioral Health is not necessarily required to agree to those restrictions. PHI of Minors may be released to parents or legal guardians upon written request. Minors have the right to restrict their parents or guardians from obtaining any PHI about them by written request. You have the right to access a copy of PHI about you contained by Emerald Behavioral Health; this usually includes clinical records and billing records. We may charge you a fee for the costs of copying, mailing and supplies necessary to fulfill your request. We may deny your request to inspect and copy your PHI in certain circumstances. If you are denied, you may request that the denial be reviewed. If you feel that PHI about you is incomplete or incorrect, you may request and amendment in writing to Emerald Behavioral Health for as long as the PHI is maintained. You must include valid reason that supports your request. If your request for amendment is denied, you have the rights to file a statement of disagreement and file a rebuttal statement. You have the right to receive an accounting of disclosure we have made on your behalf to you PHI for purposes other than treatment, payment, of health care operations. The accounting will exclude: disclosures made directly to you or that you have authorized, disclosures to friends or family involved in your care, and disclosures for notification purposed. In order to receive an accounting you must do so in writing to Emerald Behavioral Health. Your request must specify the time period, but not longer than six years. Your first request is free of charge within a 12-month period, but you may be charged for additional accountings. We will notify you of the cost up front, and you will have an opportunity to withdraw or modify your request. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. Example: You may request that we contact you only in writing or at a different residence or post office box. To request confidential communication of PHI about you, you must submit a request in writing to ELRod Center. Your request must state how or where you would like to be contacted. We will accommodate all reasonable requests. The following list are main examples of how we may use and disclose PHI:

- Treatment - Information obtained by Emerald Behavioral Health will be used for treatment plans and kept in your clinical records.
- Health Care Operations - Emerald Behavioral Health may use information in your clinical record to monitor the performance of the counselor or staff providing treatment to you. This information will be used to continually improve the quality and effectiveness of the health care service we provide.
- Business Associates - There are some services provided by us through contracts with business associates. To protect PHI about you, we require the business associate to appropriately safeguard the PHI. Communication with the individuals involved in your Care - Health professionals using their professional judgement may disclose to a family member, other relatives, close and personal friend, or any person you identify.

As required by Law - We must disclose PHI about you when required to do so by law.

- Please initial here: _____ I understand that only Individual/Family/Group therapy falls under the umbrella of PHI, and any information related to the other programs at Emerald Behavioral Health are non-HIPPA information.
- Please initial here: _____ I also understand that Emerald Behavioral Health will keep records of non-identifiable demographic and treatment outcome information for research purposes and to keep a record of the efficacy of the programs.

By signing, I acknowledge that I have received a copy of this notice and have read the contents.

Client/Parent/Guardian:_____ Date: _____

Client/Parent/Guardian:_____ Date: _____

Staff signature: _____Date: _____

CONFIDENTIALITY POLICY

You have the right to confidential treatment. We will not notify or release information to anyone outside this facility without written permission. Any information given to the family, employer, or to other agencies has to be permitted by you. In addition, you have the right to refuse, revoke, or cancel any release signed, if you should change your mind.

Parent or legal guardian must provide consent for outpatient services to minors age 13 years of age or younger. Minors 14 years of age or older may provide informed consent for outpatient services independent of parental or guardian consent. As a professional staff, we work together and therefore will exchange information and ideas to improve your treatment. These disclosures are limited to staff associated with our facility professionally. Emerald Behavioral Health follows State and Federal requirements for individual confidentiality except in the following circumstances:

Court Subpoena: If you are involved in a court trial and the opposing attorney wishes to subpoena your records, they can. It is Emerald Behavioral Health policy to not surrender your chart unless the attorney petitions the judge for a court order. We must comply or be subject to contempt of court. Even in this circumstance, the judge must not reveal the contents of your record to anyone unless it has direct bearing on the trial. Example: If you are involved in a child custody hearing and your spouse has your record subpoenaed to prove that you are chemically dependent, the judge would first have to decide whether it was relevant to the case before allowing the contents of the chart to be brought to trial. Child Abuse: This involves the State law requiring the disclosure to the Children's Services Division of any suspected mistreatment of children to the point where it is determined to be neglect or child abuse. Endangerment: If the staff believed you were about to attempt suicide, take someone's life, or injure someone, the therapist may over-ride confidentiality per duty to warn. Life-Threatening Emergency: If you have been hurt, taken to the hospital and are unconscious, social information could save your life. In such a case, Emerald Behavioral Health can use discretion to provide information needed. It is Emerald Behavioral Health's intent to not use an individual's information in a harmful way but for you to get well. We will protect all information about you to the fullest extent allowed by law. If you have any questions about these expectations or about your right to confidentiality, please notify the counseling staff immediately.

I have read, had explained to me, and fully understand my rights regarding confidentiality.

INDIVIDUAL GRIEVANCE PRODECURE

Any individual who believes that he or she has been treated illegally, unethically, or unfairly has access to the Individual Grievance Procedure. At any time a grievance may be filed Maegan Mexicotte, LPC. If a resolution is not obtained, the following entities can be contacted as well: Disability Rights of Oregon, 503-243-2081 or 1-800-452-1694 The appropriate licensure or certification board: Oregon Board of Licensed Professional Counselors and Therapists, 503-378-5499 Oregon Board of Psychologist Examiners, 503-378-4154 Oregon Board of License Social Workers, 503-378-5735

Attendance Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $25 if I fail to give at least 24-hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of $25 if I fail to show for my appointment.

3. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

6. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the attendance policy of this therapist.

Client/Parent/Guardian:_____ Date: _____

Client/Parent/Guardian:_____ Date: _____

Staff signature: _____Date: _____