Thrive Behavioral Health Center

STATE OF OHIO NOTICE FORM (HIPAA)

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes in most instances without your consent under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), but we obtain consent in another form.

To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
    - Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.
    - Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage, which would include an audit.
    - Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization
We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of services, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain a written authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. Note, psychotherapy notes may not be required to be released for eligibility or underwriting purposes.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization as allowed by law, including, but not necessarily limited to, the following circumstances:

Child Abuse: If, in our professional capacity, we know or suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or mentally retarded/developmentally disabled child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, we are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or other appropriate governmental agency.

Adult and Domestic Violence: If we have reasonable cause to believe that an elderly adult age 60 or over, or an adult mentally retarded/developmentally disabled person is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, we are required by law to immediately report such belief to the County Department of Job and Family Services and/or other appropriate government agency. If we believe that a patient or client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the patient's or client's records. : If we have reasonable cause to believe that an elderly adult age 60 or over, or an adult mentally retarded/developmentally disabled person is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, we are required by law to immediately report such belief to the County Department of Job and Family Services and/or other appropriate government agency. If we believe that a patient or client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the patient's or client's records.

Serious Threat to Health or Safety: If we believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). We will inform you about these notices and obtain your written consent, if we deem it appropriate under the circumstances.

Worker's Compensation: If you file a worker's compensation claim, we may be required to give your mental health information to relevant parties and officials.

IV. Patient's Rights and Thrive Behavioral Health Center, LLC' Duties Patient's Rights:

- Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request, except under certain limited circumstances.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing one of us, so you may not want us calling your home and leaving a message on an answer machine. Upon your request, we will send your bills to another address and/or place calls to another number. If your request is reasonable, then we will honor it.
- Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record.
- Right to Amend. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process. Accounting is only required to be kept for a six year period.
- Right to a Paper Copy. You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Thrive Behavioral Health Center, LLC' Duties:

- We are required by law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice and to make those changes effective for all of the PHI we maintain.
- If we revise our policies and procedures, we will make available a copy of the revised notice to you on our website and you may always request a paper copy.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may file a complaint with us and we'll consider how best to resolve your complaint. Contact our Privacy Officer, listed below, if you wish to file a complaint with us. In the event that you aren't satisfied with our response to your complaint, or don't want to first file a complaint with us, then you may send a written complaint to the:

Secretary of the U.S. Department of Health and Human Services in Washington, D.C. or to:

The ADAMHS Board of Cuyahoga County

2012 West 25th St,

Cleveland, Ohio 44113.

216-241-3400

There will be no retaliation against you for filing a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on December 31, 2016.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will make available a copy of the latest version on our website, or, upon your request, we will provide it in writing to you via U.S. mail.

VII. Privacy Officer

The Privacy Officer for Thrive Behavioral Health Center, LLC is Bridgette Lewis, 3637 South Green Rd, Unit 3G, Berachwood, OH 44122, (216) 220-8774. You may contact her if you have any questions about any Privacy Policies or if you wish to file a complaint with the practice.

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The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 42 CFR.

Your 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 your written consent unless otherwise provided for by the regulations. You may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless you revoke your consent earlier, this consent will expire automatically as follows: one year after today's date as listed on this form.

ACKNOWLEDGEMENT OF RECEIPT OF:

Thrive Behavioral Health Center, LLC

NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Thrive Behavioral Health Center, LLC’ Notice of Privacy Practices.

Client Name (Print)

Client Signature (must be full signature)

Today's Date

The below portion is to be completed by a Thrive employee if client consent is obtained verbally.

Witness Name

Witness Signature

Thrive Behavioral Health Center

Informed Consent to Screen, Evaluate and Treat

As a patient of Thrive Behavioral Health Center, I have the right to make informed decisions regarding my care. My rights include being informed of my health status, being involved in care planning and treatment, and being able to request or refuse treatment. Thrive Behavioral Health Center healthcare professionals will discuss with me the nature of my symptom(s) and condition(s), the proposed treatment(s), the benefits and risks associated with treatment, the probability of successful outcomes, and alternatives to the proposed treatment(s), if any or as applicable. I acknowledge and understand that I may revoke consent to further care at any time by informing consent@thrivepeersupport.com or my Thrive Behavioral Health Center healthcare professional of my desire to do so.

By accepting screening, evaluation, and treatment from any Thrive Behavioral Health Center healthcare professional, I authorize providers using the Thrive Behavioral Health Center platform to perform all clinical and professional treatment and services deemed necessary in their determination in order to ensure program outcomes/appropriateness, and acknowledge that I have been informed of the benefits and risks of such treatment and services by the Thrive Behavioral Health Center healthcare professional(s) providing my care.

Services provided by Thrive Behavioral Health Centers, LLC:

· Peer Support Services: Self-Help, Individual Advocacy, Pre-Crisis and Post Crisis Support, Housing, Education/Employment

· Assessments: Mental Health Assessments, Planning, Implementation and Evaluation of care

· SUD Case Management: Collaboration and Coordination of care

· Employment Services: Job development and support services

· General Services: Medical services, Individual counseling, Group counseling,

· Community Psychiatric Supportive Treatment

Medical Records/Confidentiality

I have been advised and understand that Thrive Behavioral Health Center and its partnering providers adhere to all state and federal laws of confidentiality, including confidentiality of your personal information (i.e. protected health information, or "PHI") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and any suspected violations of the law must and will be reported. Thrive Behavioral Health Center and its partnering providers are, behavioral health and addiction treatment providers, and will not disclose with anyone any information regarding your treatment or your PHI, other than what HIPAA authorizes for coordination of care, emergency care, quality management, insurance verification, or claims payment purposes, unless you specifically authorize Thrive Behavioral Health Center to do so in writing. You have been provided with a copy of Thrive Behavioral Health Center's Notice of Privacy Practices with this Consent. You may also review Thrive Behavioral Health Center's Notice of Privacy Practices at any time by visiting https://thrivepeersupport.com/ or requesting a copy from a Thrive Behavioral Health Center representative at consent@thrivepeersupport.com.

Patients are allowed to access their file and patient information.

I give my consent for the duration of my treatment and 90 days after discharge for Thrive Behavioral Health Center and its partnering providers to release information regarding my progress and location in treatment to referring agencies and healthcare providers, as well as probation and officers of the Court (if applicable) for the purpose of assuring compliance with an order for treatment (if requested).

Federal regulations do not protect from disclosure information related to a patient's involvement in a crime. We are

required to report suspected abuse to children, those who are disabled, or the elderly. Information may be shared in times of medical emergency. If required by a court order signed by a judge, information will be released at that time. If a patient shares a specific plan or intent to harm themselves, that information may be shared.

In case of severe medical emergency, I have listed an emergency medical contact on my Thrive Behavioral Health Center account, or on a release form, and authorize Thrive Behavioral Health Center and/or its partnering providers to contact that party should such an emergency occur.

Consent for Telehealth Treatment

I understand that Telehealth/Telemedicine ("Telehealth") means that I will be able to consult with a Thrive Behavioral Health Center healthcare provider about my health and medical concerns/needs through an interactive electronic video connection, and my Thrive Behavioral Health Center healthcare provider will be able to screen, evaluate, and treat me via such a connection. I further understand that Telehealth involves the use of electronic communications, software, and systems to enable healthcare providers at different locations to share individual PHI. The electronic software, systems, and equipment used to facilitate my care will incorporate industry-standard and HIPAA-compliant network, software, and hardware security features and protocols to protect the confidentiality of my identity and PHI, and will include measures to safeguard data transmitted, as well as ensure its integrity against intentional or unintentional breach/corruption.

My healthcare provider and/or Thrive Behavioral Health Center has explained to me how the Telehealth technology will be used for my treatment and services.

The benefits of Telehealth include, but are not limited to:

1. I may not need to travel to the consult location.

2. I have improved access to a specialist through this consultation.

3. I have flexibility in scheduling around work, family, and other personal obligations.

4. I receive more efficient screening, evaluation, and treatment.

I understand there are potential risks with Telehealth may include:

5. The video connection may not work due to technical or connectivity issues, or that it may stop working during the consultation, resulting in delays in treatment.

6. The video picture or information transmitted may not be clear enough to be useful for the consultation, resulting in delays in treatment.

7. In very rare circumstances security protocols could fail, causing a breach of privacy or PHI.

8. I may be required to go to the location of the consulting provider if it is felt that the information obtained via Telehealth was not sufficient to make a diagnosis, if state or federal regulations require an in-person session, or my physical presence is required to access specific medications or services.

I give my consent to utilization of Telehealth and being interviewed by the consulting health care provider via Telehealth. I also understand other individuals may be present to assist with technology use, including another healthcare provider and/or telepresenter, and that they will take reasonable steps to maintain confidentiality of any information obtained. I acknowledge that I have been adequately informed of Telehealth's risks and benefits, and further understand that I have the right to ask my healthcare provider to discontinue use of Telehealth at any time, but that such a request may result in discharge from care by Thrive Behavioral Health Center and its partnering providers.

I hereby release Thrive Behavioral Health Center and its partnering providers and any other person participating in my care from any and all liability which may arise from the taking and authorized use of backups, data, videotapes, digital recordings, films, audio, and photographs.

Consent for Consultation with Relevant Specialists - Behavioral Health Integration and Collaborative Care Management

I understand that my Thrive Behavioral Health Center health provider and/or supporting and coordinating Thrive Behavioral Health Center staff may consult with relevant specialists related to my care, including psychiatric consultants, pharmacy professional staff, laboratories, primary care or referring health providers, and health care personnel who may collaborate or affiliate with Thrive Behavioral Health Center for my overall health care needs, and/or referred me to Thrive Behavioral Health Center's health services. These services are broadly considered Behavioral Health Integration services, or Collaborative Care Management ("BHI"). My healthcare provider and/or Thrive Behavioral Health Center staff has explained to me that they are the billing practitioner for the services that are performed by Thrive Behavioral Health Center health providers.

I understand that in all such instances of BHI, Thrive Behavioral Health Center will only share information necessary for my health care and will limit the health information shared to that which is permissible by law. In circumstances where consultation falls outside of the ordinary BHI described in this section (such as when transferring your care to another treatment provider who is not affiliated with Thrive Behavioral Health Center), we will always ask for your express written permission.

Delegation

I may delegate my right to make informed decisions to another person. To the degree permitted by state law, and to the maximum extent practicable, Thrive Behavioral Health Center must respect my wishes and follow that process. In the case that I am unable to make medical decisions because I am unconscious or otherwise incapacitated, Thrive Behavioral Health Center may consult with my advance directives, medical power of attorney, patient representative, or emergency contact, if any of these are available. In such cases, relevant information will be provided to the applicable representative so that informed health care decisions can be made for me. As soon as I am able to be informed of my rights regarding my treatment, Thrive Behavioral Health Center will provide that information to me.

Patient Financial Responsibility

By accepting treatment from Thrive Behavioral Health Center or a partnering healthcare professional, I acknowledge and accept financial responsibility for all charges for any and all services rendered to me. Before my first session with a Thrive Behavioral Health Center partnering provider, I understand that I will be required to provide my current insurance coverage information. This information is not required at the time of registration for Thrive Behavioral Health Center services but will be required before treatment and services begin.

While insurance may confirm my benefits, I understand that confirmation of benefits does not guarantee coverage and agree that I am ultimately responsible for any unpaid balance due for services otherwise covered by insurance. It is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network limit, prior authorization requirement, or limitation for services received, and I understand that I must make payment in full for these services that are not covered at the time of service or upon receiving a statement of account from Thrive Behavioral Health Center. Clients with Medicaid benefits have 100% of services covered with no financial responsibility to the client.

Thrive Behavioral Health Center will make reasonable efforts to confirm insurance, obtain prior authorizations, and obtain referrals as may be required by my insurance carrier. I understand and agree that it is my responsibility to know if my insurance carrier requires a referral from my primary care physician and that it is up to me to obtain the referral if Thrive Behavioral Health Center cannot obtain the referral directly on my behalf. I understand that without this referral, my insurance may not pay for any services and that in such cases I will be financially responsible for all services rendered to me, and filing any claims or appeals against my insurance for reimbursement.

I understand and agree that I am required to update my insurance on file with Thrive Behavioral Health Center and/or inform a Thrive Behavioral Health Center representative at intake@thrivepeersupport.com upon any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am ultimately financially responsible for the balance in full.

Understanding the financial policy contained here is an important part of your responsibility as a patient. Patients are welcome to ask questions about the financial policy at any time or about financial assistance programs that may be available to them by contacting a care coordinator at intake@thrivepeersupport.com. Patients are responsible for the timely payments of all balances on their accounts.

Insurance Authorization

By accepting treatment from Thrive Behavioral Health Center and its partnering healthcare professionals, I authorize the release of any PHI or other information regarding my treatment to any insurance carrier or other applicable third-party payor or financially responsible entity or individual for the purpose of securing payments for services rendered to me, and assign and set over to Thrive Behavioral Health Center any benefits for the cost of treatment that I may be entitled to as a result. I further authorize the third-party payor to make payment directly to Thrive Behavioral Health Center.

Self-Pay Policy and Credit Card Authorization

Patients paying “out-of-pocket” for treatment, including co-payments, co-insurance, and deductibles, as well as charges for services not covered by insurance, must pay in full at the time of service. Payment is accepted via most major credit cards.

By providing my credit card information, whether electronically through Thrive Behavioral Health Center’s secure patient care application, a third-party payment portal, or to Thrive Behavioral Health Center personnel, and by receiving telehealth services that are billable to me, I (i) authorize Thrive Behavioral Health Center to charge my credit card for any and all unpaid amounts that Thrive Behavioral Health Center or my insurer determines are my responsibility, and (ii) I agree to pay all amounts charged pursuant to this consent and authorization in accordance with the issuing bank cardholder agreement. I agree that Thrive Behavioral Health Center may charge my credit card for such amounts at the end of my telehealth visit or at a later date.

I will be billed for all unpaid balances deemed by Thrive Behavioral Health Center or my insurer to be my responsibility and agree to pay such amounts in full. Thrive Behavioral Health Center may at its sole discretion charge late fees of 1.5% per month on unpaid balances starting 30 days after the first statement is mailed to me, as well as a $30 fee for returned checks. Delinquent accounts may be turned over to a collection agency and may be subject to collection and/or legal fees. I understand that Thrive Behavioral Health Center reserves the right to deny non-emergency services if my account is delinquent.

Medicare/Medicaid Patient

If you are a Medicare or Medicaid patient, in order to receive treatment you must provide to Thrive Behavioral Health Center, or ensure your referring provider has provided, both your Medicare/Medicaid ID card and, if applicable, your secondary insurance ID card. If Thrive Behavioral Health Center does not receive the proper information for a secondary insurance, any such insurance will not be billed. It will be your responsibility to pay the balance and then file a claim with such insurance for reimbursement.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE CONSENT TO FURTHER THRIVE BEHAVIORAL HEALTH CENTER OR THRIVE BEHAVIORAL HEALTH CENTER PARTNERING PROVIDER TREATMENT AT ANY TIME BY INFORMING A THRIVE BEHAVIORAL HEALTH CENTER REPRESENTATIVE OR MY PROVIDER OF MY DESIRE TO DO SO. HOWEVER, SUCH REVOCATION SHALL NOT AFFECT ANY TREATMENT, SERVICES, DISCLOSURES OR OBLIGATIONS ALREADY MADE IN COMPLIANCE WITH YOUR PRIOR CONSENT TO TREATMENT. THRIVE BEHAVIORAL HEALTH CENTER PROVIDES THIS NOTICE TO ITS PATIENTS IN ORDER TO COMPLY WITH HIPAA, THE CENTERS FOR MEDICARE & MEDICAID SERVICES, AND ANY APPLICABLE STATE AND FEDERAL LAWS.

Participant Name

Participant Signature (must be full signature)

Today's Date

The below portion is to be completed by a Thrive employee if client consent is obtained verbally.

Witness Name

Witness Signature