Informed Consent for Outpatient Treatment

Your Rights: As a client of H.A.L.O. Educational Systems LLC, you have several rights. You have the right to:

- Decide not to participate in specific types of services, and to decide to terminate services.
- A safe environment, free from emotional, physical, and sexual abuse.
- Be treated with respect by self, staff, and other clients.
- Be free from discrimination from self, staff, and other clients, including but not limited to racial, sexual, religious, age, gender, or economic discrimination.
- Complete and accurate information about your treatment including goals, methods, potential risks and benefits, and progress.
- Information about the professional capabilities and limitations of any professional involved in your treatment.
- Receive treatment from trained and qualified professionals.
- Written information about fees, payment methods, and lengths and duration of sessions and treatment.
- Be informed about the limits of confidentiality, the situations in which your counselor and/or the agency is legally bound to disclose information to outside persons or agencies, and the types of information that will be disclosed.
- Know if your counselor will discuss your case with supervisors or peers.
- Request the release of your clinical information to any agency or person that you choose.
- Be referred to appropriate community services, based on individual needs, as we are able to identify them.
- If you are asked to leave the program, to know why you are being asked to leave and what conditions you must meet in order to return to H.A.L.O. Educational Systems, LLC.
- You have the right to cancel 24-48 hours prior to a scheduled appointment.

What to expect from the H.A.L.O. LLC, Program: Individual and group Counseling. It is a process in which you work with a counselor in order to resolve problems and meet agreed upon goals. Counseling is not like a visit to a medical doctor. Rather, it calls for a *very active effort on your part.* In order for counseling to be most successful, you will have to work on things that are discussed both during sessions and at home. Counseling can have risks and benefits. Counseling often involves discussing unpleasant aspects of your life and you may experience uncomfortable feelings as a result. However, counseling has also been shown to help individuals resolve specific problems and reduce feelings of distress.

Appointments: Our time will normally be 50 minutes and are scheduled based upon your needs. We ask that you be on time for appointments. If you need to cancel or reschedule an appointment, please contact your counselor as soon as possible. If you do not show up for two (2) sessions in a row, your counselor may terminate services. **We will bill you for missed appointments** that have not been canceled or rescheduled at least 24 hours in advance at your normal session rate. **All cancellations must be done by phone call ONLY, No e-mail or texting.**

Drug Screening: As part of your program clinicians have the option of performing oral fluid testing both in person and/or remotely during your routine telemedicine visits. In partnership with our lab Aegis, we mail the kit directly to you. You and a member of the HALO team will complete instructions on administration. Your package will include a return mailer pack you can drop in the mailbox for USPS pickup. HALO clinicians will be observing the oral fluid collection via the video platform.

Fees and Payment: *A credit card is asked to be placed on file.* A standard $30 reimbursable charge will occur for each service while awaiting payment arrangements. HALO participates in most insurance plans. We are a fee for a service institute. Depending on program service, standard pricing ranges from $65.01 fee to $169.94 per session. Although we will not refuse services to any eligible person because of an inability to pay in full, we will ask that you make payment plan arrangements with a member of our financial department and any balance must be paid in full prior to receiving additional services unless special arrangements are agreed upon with the managing director.

Dual Relationship Disclosure: HALO has various clinicians; however, it is our ethical responsibility to disclose in writing that the managing director's daughter is employed at HALO in the operations department.

H.A.L.O. accepts VISA, MASTERCARD, and DISCOVER.

Individuals referred to H.A.L.O. Educational Systems, LLC. As a court order or a DWI/DUI service plan must have a **ZERO** balance before completion paperwork will be sent to an attorney/court/ or State.

Confidentiality: The confidentiality of client records maintained by H.A.L.O. Educational Systems, LLC. is protected by federal law and regulations. Generally, we may not say to a person outside of this agency that a client receives services here, or disclose any information identifying a client as an alcohol or other drug abuser. The exceptions to this include (a) permission granted to_____ , _____*(relationship)* (b) if the disclosure is permitted by court order, (c) the disclosure is made to medical personnel in a medical emergency, or (d) to report suspected child abuse and neglect or suspected elder or incapacitated adult abuse, neglect, or exploitation.

Violation of the federal law and regulations by this agency is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines. Federal law and regulations do not protect any information about a crime committed by a client either on HALO property, against any person who works for H.A.L.O. LLC, or any threat to commit such a crime. (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)

Consultation and Supervision: Each counselor at H.A.L.O. Educational Systems, LLC participates in regular clinical supervision and peer case consultation with clinicians who are bound by the same standards of confidentiality. The goal of this supervision and consultation is to provide the most effective and helpful services to our clients and to continually improve our skills as clinicians.

Treatment Records: The laws and standards of professional counseling mandate that we keep records of your treatment. You have the right to receive a copy of your record, or we can prepare a summary of your treatment. Due to the professional nature of these records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to access your records, there is a fee. Please provide a written request, we recommend that you arrange to do so in the presence of your primary counselor so that the contents can be discussed. *We reserve the right to withhold the release of your records to outside agencies if you have an outstanding balance*.

Emergency Services: Your counselor's regular office hours are_____. In the event of an emergency when your counselor is not available, you can call 603 359-3321 or These supports are available to you 24 hours a day, 7 days a week. **Hotline at 800-639-6095** or **Suicide Hotline 800-273-8255** WCBH **Emergency Services 1-800-564-2578**. DHMC **Emergency 1-800-556-6249.**

Consent to Contact: I grant permission to receive – (Please circle best means of communication)

Phone - Voicemail | Text | Email as separate consent is required for telehealth services.

Phone # ( ) _____ Email: _____@_____

We will NOT correspond via text other than appointment reminders.

Signed Consent for Treatment: By signing the agreement below, you are confirming services and responsibility to pay for all services rendered and additionally that you have read and agree to all conditions stated above.

"HALO and I have agreed that I am responsible for all fees. I am authorizing a continued $30 session charge on my credit card while insurance and financial arrangements are secured. I agree to ensure the clinical rate of $ 120 - 137.08 per session is covered. I am authorizing my _____ insurance/ CARD to be billed. Insurance cards will be photocopied. I have read and/or had explained all of the preceding statements. I understand my rights and responsibilities for the services rendered by H.A.L.O. LLC. I agree to these conditions of my counseling as provided in this agreement."

_____ _____

Client Signature Date

_____ _____

HALO Signature Date

CANCELLATION NOTICE

www.HALOEducationalSystems.com

HALO Educational Systems has 24-hour cancellation/rescheduling policy.

PLEASE call (603) -523-8804

For all of our HALO services, if an appointment is missed, canceled, or changed with less than 24 hours' notice, there will be a **$75 charge**. HALO Educational Systems realizes that there are many things that come up in people's day to day lives.

While truly sympathetic, HALO Educational Systems cannot absorb the financial responsibility of any last minute cancellations. HALO Educational Systems does not double book appointment times but rather reserves specific times for each patient affording individual care. In fairness to all clients, this policy is in effect regardless of the reason for the cancellation.

By signing below, you acknowledge that you have read and understand the Cancellation Policy

(You should note that insurance companies do not typically reimburse for missed appointments.)

_____ _____

Signature of Client/Guardian Date

_____ _____

HALO Signature Date

2025

H.A.L.O. Educational Systems, LLC.

Helping All Learn Options

Canaan, New Hampshire 03741
Phone : (603) 523-8804 Fax (603) 795- 0498

CONSENT/AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I,_____(Client) DOB _____

authorize **H.A.L.O. Educational Systems, LLC**. to ☐ disclose to obtain from ☐

(Person)_____(Agency_____

(Address)_____

PHONE ( ) _____ EMAIL: _____@_____

(Name or Title, Address and Phone Number of the Person or Organization to which the Disclosure is to be made or received

the following information: (Please Initial each Consent)

☐	Attendance in treatment	☐	Social/Family History
☐	Course and results of treatment	☐	History of Medical treatment
☐	Treatment plan	☐	History of Psychiatric treatment/ Counseling
☐	Treatment recommendations/Aftercare plan	☐	Medical history (including medication history)
☐	Discharge plans/Discharge summary	☐	Drug/Alcohol test results
☐	Substance use history	☐	Biopsychosocial Assessment
☐	Diagnostic summary and diagnoses	☐	Substance abuse Evaluations and recommendations
☐	Legal History	☐	Physical Exam/TB test
☐			
☐	Other (please specify) _____		

The purpose or need for the disclosure authorized herein is to: *(provide integrative treatment approach)*_____

(Purpose of disclosure, as specific as possible)

I understand that my alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it. If not previously revoked, this consent expires automatically as follows: _____*(One Year from the date of signature)*_____

(Specifications of the date, event, or condition upon which this consent expires)

I understand that generally my treatment may not be conditioned on whether I sign a consent form. I have read this release and understand its contents.

_____ _____

Signature of Client *Date*

_____ _____

HALO Signature *Date*

HALO
Corporate: 44 Roberts Rd
Canaan, NH 03741
www.HALOEducationalSystems.com

Private Practice Policies Regarding Telehealth

TELEHEALTH / TELEMEDICINE

I understand that telehealth (or telemedicine) is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when they are located at a different site than the provider; and hereby consent to **staff/affiliates at HALO Educational Systems, LLC** to provide psychotherapy services to me via telehealth.

I understand that:

(a) Services and procedures that are not covered in a face-to-face setting under my insurance are not covered under telehealth.
(b) Services delivered via audio-only telephone, facsimile, or electronic mail messages are not considered telehealth and are not covered.
(c) HALO will determine whether the conditions being diagnosed and/or treated are appropriate for a telemedicine encounter.
(d) The federal and state laws that protect privacy and the confidentiality of medical information also apply to telehealth psychotherapy.
(e) HALO will contact me through a video portal that is HIPAA-compliant for security, but that there are no absolute guarantees that such technological boundaries cannot be broached or that information will not be lost during technological failures.
(f) Costs for psychotherapy provided via telehealth may be covered by insurances when the client receiving those services is located in a state in which the therapist holds a current license to practice and that HALO is currently licensed in Vermont and New Hampshire only.
(g) I will be responsible for any copayments or coinsurances that apply to my telemedicine visit or will be paying HALO's fee in full if coverage is not available.
(h) 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.
(i) I may revoke my consent orally or in writing at any time by contacting HALO. As long as this consent is in force (has not been revoked) HALO may provide health care services to me via telemedicine without the need for me to sign another consent form.

Client Signature_____Date_____

Please Print full name_____

HALO Signature_____Date_____

Health Questionnaire

Name: _____ Date: _____
Age: _____ Date of Birth: _____ Height: _____ Weight: _____
Primary Care Physician: _____
Dr. Address & Phone: _____

When was your last medical exam? _____
How would you rate your present health? ____ Good ____ Fair ____ Poor
List any medical conditions that you have: _____
_____
Name of the physician monitoring this condition(s): _____
List any medications and amounts that you are currently taking_____
_____
Who prescribes these medications to you? _____
Any vitamins:_____
Have you seen a psychiatrist or counselor before? Yes ____ No ____ When? _____
Please explain: _____
_____
Have you ever had an accident? ___ Head Injury? _____

When do you go to bed? _____ What grade are you in/level of education?_____
do you like school?_____ Did you/do you have any significant relationships?__

Check any of the following problems that you experience (in past year):

____ Lack of appetite	____ Frequent Colds/flu	____ Bladder control
____ Appetite Change	____ Stomach problems	____ Bowel problems
____ Nervousness	____ Fatigue	____ Anxiety
____ Fears/phobias	____ Obsessive thoughts	____ Compulsive behaviors
____ Panic attacks	____ Confusion	____ Nightmares
____ Intrusive thoughts	____ Sleep disturbance	____ Difficulty concentrating
____ Flashbacks	____ Depression	____ Feelings of unreality
____ Headaches	____ Difficulty relaxing	____ Pain

____ Other medical concerns: _____
Any Parent History of above: _____

Concussions_____ Loss of Consciousness _____
Surgeries (past year):_____
Emotional/Social/Behavioral concern:_____

Clinician Use Only

Notes:

Referrals Made:

Follow-up needed:

H.A.L.O. Educational Systems, LLC.
Canaan, New Hampshire 03741
Lebanon, NH 03766
Phone : (603) 523-8804 Fax: (603) 523-8804

Notice of Privacy Practices

What is this notice?
This notice was prepared to provide you with an understandable explanation about how we may "use" and "disclose" your "protected health information." Health information is an indispensable part of healthcare treatment, payment and operations; without access to health information, the healthcare system can not function. A Federal Law called the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct (HIPAA), or the Privacy Rule, was created to support your privacy and rights surrounding your health information.

We understand that health information about you is very personal. H.A.L.O. is committed to insuring the privacy and confidentiality of your personally identifiable health information. All employees and volunteers must sign a confidentiality agreement when hired.

An informed client is an important ally for us in meeting these goals. We hope you will take the time to read our notice and to call us if you have any questions.

Some useful definitions
Protected Health Information ("PHI") - Any information, created by us in any form that identifies and is related to the past, present, or future: 1) Physical or mental health of the individual;
2) Provision of health care to the individual; or
3) Payment for health care provided to the individual.

If all personal identifiers have been removed from the information, it is considered "de-identified health information" and may be used more freely than protected health information.

"Uses" and "Disclosures" - We use these terms as they are defined in the Privacy Rule. We "use" your protected health information when we examine, review, analyze, or share it within H.A.L.O., LLC. We "disclose" your protected health information when we release, transfer, provide access to, or share it in any other way with any other organization or individual, for example to a state agency or to a referring provider.

How do we use and disclose your protected health information?
The Privacy Rule permits us to use and disclose your "protected health information" (PHI) for treatment, payment, and healthcare operations. Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, require that we ask for your written consent to disclose your "protected health information." The following describes in general how we may use or disclose your health information for treatment, payment, and health care operations:

Treatment: We may use or disclose your health information to provide and coordinate your treatment. H.A.L.O. may use or disclose your health information among members of your treatment team or other personnel within H.A.L.O.. If healthcare providers outside of H.A.L.O. request your health information, we will ask you for your written consent before sharing the information.

Payment: We may use and disclose health information about you so that the services you received from us may be billed for and payment collected.

Health Care Operations: We may use and disclose health information about you within H.A.L.O. to make sure that you receive quality care. For example, we may use health information to review our services, to evaluate the performance of our staff, or to review your records if you file a complaint.

What other ways may we use and disclose your health information?

Public Health Information (these are required by law): We may use or disclose your health information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. For example, health information may be used or disclosed for an Involuntary Emergency Admission or to report abuse or neglect of minors, elders, or dependent adults.

Health Oversight Activities: We may disclose health information to a health oversight agency for them to make sure we are following the law. (Audits, inspections, investigations, or licensure)

Emergency Situations: If an emergency happens to you, we may need to release your health information, without your consent, to medical personnel so they can treat you.

As Required by Law: We may disclose health information about you in situations not already mentioned when required to do so by federal, state, or local law.

Research: We may disclose your health information to researchers when you have agreed to participate in a study.

Law Enforcement Activities: We may disclose health information to a law enforcement official for law enforcement purposes when the information is needed to identify or locate a suspect, fugitive, material witness, or missing person; to report a death that may be the result of criminal conduct; to report criminal conduct occurring on our premises; if we receive a court order or subpoena to produce your health information; if a medical examiner requests your health information; or to the State or District Attorney's Office if you are the victim of a crime. Such releases of information will only be made after reasonable efforts to contact you for your authorization. If we cannot contact you, we will obtain legal advice, but we may be required to release your records.

What are your privacy rights?

The Federal Privacy Rule gives you several new rights with respect to your protected health information (in addition to those rights you already have under state law). Beginning April 14, 2003, you have the following rights to your health information:

- **Right to a Paper Copy of this Notice:** You have the right to receive written notice of our privacy practices (That's this document.) If you have received this notice electronically, you have the right to a paper copy if you want it.
- **Right to Request Restrictions:** You have the right to ask for further restrictions on the ways in which we use and disclose your protected health information. We are not required to agree to a requested restriction. We will not agree to any request unless we feel that we can fully meet our commitment.
- **Right to Request Confidential Communications:** You have the right to ask that we communicate with you in a certain manner or at a certain location. We will make efforts to accommodate reasonable requests. You must make this request in writing.
- **Right to Inspect and to Copy:** You have the right to see and get a copy of your treatment record or any other protected health information that we keep in a regular paper or electronic file. We may charge you a reasonable fee for copies, consistent with state law. You must make this request in writing. We may ask for a verification of identity as you make these requests. (Note: There are a few situations specified in the Privacy Rule where this right does not apply.)
- **Right to Request an Amendment:** You have the right to ask for an amendment of your protected health information. Entries are not deleted from medical records because of legal requirements but may be corrected or amended by the author of the entry. You may request an amendment of your

treatment record or other protected health information that we keep in a regular file. You must make this request in writing. If the information is accurate and complete as determined by the author of the entry, we will decline the request for amendment but will include your request and statement of disagreement in your file.

- **Right to Request a List of How We Shared Your Health Information:** You have the right to receive a written accounting of the disclosures we have made of your protected health information. This accounting does not include disclosures for treatment, payment or healthcare operations, disclosures authorized by you, and certain other exceptions. You must make this request in writing.
- **Right to Designate a "Personal Representative:"** You have the right to designate a "Personal Representative" to help you exercise your rights concerning your protected health information. This personal representative must be designated in writing, and must show this designation any time he or she wishes to exercise the rights attached to it. New Hampshire and Vermont State laws apply to the rights and responsibilities of personal representatives.

Our duties to you

We are required by law to maintain the privacy of your personal health information, and to give you notice of our legal duties and privacy practices with respect to your protected health information.

We are required to abide by the terms of our Privacy Notice currently in effect.

We reserve the right to change our privacy practices (that is, to change the ways in which we use or share your protected health information as described in the Notice), so long as the new practices are permitted by the Federal Privacy Rule or other applicable law, and are described in a revised Notice of our privacy practices.

We further reserve the right to make any such revised Notice provisions effective for all protected health information we maintain, including information created or received before the effective date of the revised Notice.

Revised Notices will be posted in service locations, and will be available on request from H.A.L.O..

Questions or Complaints?

If you have a question or believe your privacy rights have been violated, you may request clarification or file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. H.A.L.O. can also assist you with your complaint, if you request such assistance.

H.A.L.O.
Canaan, NH 03741
Phone: (603) 359-3321

Secretary, Dept. of HHS

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Rm. 515 F HHH Bldg.
Washington, D.C. 20201
Phone: (202) 619-0257
Toll-Free: 1-877-696-6775

All complaints must be submitted in writing. We will respond to all properly filed complaints. You will not be adversely affected or discriminated against in any way for filing any such complaint.

H.A.L.O. Educational Systems, LLC.

Helping All Learn Options

www.HALOEducationalSystems.com

Canaan, New Hampshire 03741 Lebanon, NH 03766

Phone : (603) 523-8804 Fax: (603) 795 - 0498

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the *H.A.L.O. Educational Systems, LLC.* Notice of Privacy Practices. I understand that *H.A.L.O. educational Systems, LLC.* has the right to change its Notice of Privacy Practices from time to time and that I may contact *H.A.L.O. Educational Systems, LLC* at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Client Name (Print)

_____

Signature of Client/Legal Representative

_____

Relationship to Client

_____

Date

FOR OFFICE USE ONLY

PRINT PLEASE

I have attempted to obtain the patient's signature on this form, but was not able to for the following reason:

Date: Please document the reasons you were unable to obtain the signature.

Initials:

H.A.L.O. Educational Systems, LLC.

Helping All Learn Options

www.HALOEducationalSystems.com

PAYMENT POLICY

Thank you for choosing HALO Educational Systems LLC. Prompt payment for the services that you receive ensures that we can continue to provide you and our community with affordable, quality care. The following explains the guidelines and rules of our Payment Policy. Please read it, and feel free to ask us questions.

ABOUT INSURANCE

HALO participates with most insurance plans, including Medicare and Medicaid NH/VT. **Your insurance benefit is a contract between you and your insurance company; knowing your insurance benefits and co-pay amount is your responsibility.** You must contact your insurance company with any questions you may have about your coverage. Please be aware that you might be responsible for the entire amount of the bill, if your insurance company does not have a contract with HALO.

Please note the following:

1. **Co-payments** must be paid at the time of service. This arrangement is part of **your contract with your insurance company. Failure of HALO to collect co-payments from clients can be considered fraud**. Please help us in upholding the law, by paying your co-payment at each visit.
2. **If you have an active insurance card**, we will bill your insurance company. If any balance remains, we will bill you.
3. **If you do NOT have an active insurance card,** we will offer you financing company options (True Link) to help support your quest of wellness. Until we can verify credit extended, you will be billed for each visit, or until we can verify your insurance coverage.

****

HALO accepts personal checks, credit cards, and cash. HALO offers a Sliding Fee Scale, available to income eligible clients. A payment plan can be arranged before you make your appointment.

OTHER THINGS TO KNOW:

- **Mutual/Dual Relationship.** Although clinicians vary, it is our ethical responsibility to disclose in writing that the managing director's daughter is employed at HALO in the finance department. If you have a question or believe your privacy rights have been violated, you may request clarification from (Sherril Zani) 603-523-4501, town of Canaan, or the NHLADC Board (603) 271-2152 or express your concern in writing to U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W. Rm. 515 F HHH Bldg. Washington, D.C. 20201
- **IF YOUR INSURANCE CHANGES**, call us before your next visit. HALO will make the necessary changes to help you receive your maximum benefits. If your insurance company has not paid your claim in 45 days, HALO's billing department will follow up with your insurance company, to find out why the claim has not processed.
- **PROOF of insurance** - HALO must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you will be responsible for the balance of a claim.
- **NON-COVERED services** - Please make sure that you know which services are covered by your health insurance. If you receive services at HALO that are not covered by your insurance plan, you will be offered a financing company, but you are responsible for paying for these services.
- **CLAIMS submission** - HALO submits your claims, and assists you in any way we can. You may be asked by your insurance company to supply certain information directly to them, it is your responsibility to supply your insurance company with information that they request from you. If you are unsure about a request that you have received from your insurance company, you can call us to discuss it, and we will

try to assist you. If your claim is not paid because you have not supplied requested information, you will be responsible for paying the claim. Another reason your claim may not be paid by the insurance company, is because you have not met your deductible for the year, the claim will be your responsibility to pay.

- **NONPAYMENT - If your account is over 90 days past due, the following procedure is followed**: You will receive a letter giving you 10 days to either pay the balance in full, or make a partial payment, and set up a payment plan with our billing office. If you cannot pay your bill, call our billing department as soon as possible, to make arrangements that you can afford.

Payment card on file (Mastercard or Visa card accepted):

Name on card: _____

Card number: _____

Card expiration: _____

Card CVC: _____

Client Signature: _____ **Date:** _____

Print Full name: _____

HALO Staff Signature: _____ **Date:**_____