Cactus Garden Mental Health Services LLC
7165 E University Dr., Building 14, Suite 155
Mesa, AZ - 85207-6412

01 CACTUS GARDEN MENTAL HEALTH SERVICES, LLC NEW CLIENT PAPERWORK

Thank you for choosing Cactus Garden Mental Health Services, LLC.

Your new client paperwork contains several sections. If you are completing the paperwork through Charm Health, you must expand each category and thoroughly read the information within the corresponding section. Please do not hesitate to contact us if you have any questions or issues with completing the forms

INSTRUCTIONS:

- ***READ CATEGORIES 1 THROUGH 13 IN THEIR ENTIRETY.***
- ***COMPLETE THE FILLABLE FIELDS IN THE FINAL TWO SECTIONS (SECTIONS 12 AND 13) TO FINISH YOUR PAPERWORK AND PROCEED WITH SERVICES.***

****There are no fillable fields in sections 1 through 11.***

- ***Section 12: HEALTHCURRENT PART II (Optional - Leave blank if you do not wish to provide consent).***
- ***Section 13: CONSENT TO TREATMENT (Mandatory).***
- *All paperwork must be completed and received no later than one hour prior to your appointment time. Clients who have not completed the required paperwork within this time frame will need to re-schedule for the next available opening.*

Thank you for your understanding and cooperation.

1. HIPAA NOTICE OF PRIVACY POLICY

HIPAA PRIVACY POLICY: HIPAA (Health Insurance Portability and Accountability Act) of 1996 mandates data privacy and security for safeguarding patient's medical information. It describes how medical information about you may be used and disclosed and how to get access to this information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION: The providers of this clinic keep a record of the healthcare services we provide. You may ask to see and copy that record. Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the provider's practice, and other uses required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose and treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical/nursing/other students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical or nursing school students that see patients at our office. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as needed, to contact you to remind you of your appointment.

USE AND DISCLOSURE OF INFORMATION TO BUSINESS ASSOCIATES: We may disclose your protected health

information to third-party service providers who assist in treatment, payment, or healthcare operations. This includes individuals or organizations who help facilitate your care, such as Clinical Care Coordinators, documentation support services, secure communication platforms, or billing providers.
These providers operate under strict confidentiality obligations and are only permitted to use or disclose your information as necessary to perform their assigned duties in support of your care.

USE REQUIRED BY LAW: We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, or Inmates. Under the law, and when required by the Secretary of the Department of Health and Human Services, we must make disclosures to you.

YOUR RIGHTS: The following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your healthcare provider is not required to agree to a restriction that you may request. If the healthcare provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have a right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may have the right to have your healthcare provider amend your protected health information.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of protected health information and provide individuals with this notice of our legal duties and privacy practices. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

2. INFORMED CONSENT

INTRODUCTION: Welcome to Cactus Garden Mental Health Services LLC. We look forward to addressing your mental health care needs. We encourage your questions and participation in all aspects of your care. This informed

consent document contains important information about our professional services and business policies. Please read it carefully and ask any questions you may have. When you sign this document, it will represent an agreement between us.

Please read through this document, mark each box appropriately, and insert your signature at the bottom. By selecting "Yes" to a statement indicates that you have read and understand the information provided and agree to the terms set forth in the statement. By selecting "No" next to a statement means that you have read and do NOT understand the information provided and/or do NOT agree with the terms set forth in the statement. You must choose one.

3. CLIENT SERVICES, RIGHTS AND RESPONSIBILITIES

PSYCHIATRIC AND MENTAL HEALTH SERVICES: Psychiatric and mental health services are tailored to your individual needs, symptoms, problems, and concerns. Your provider may employ a variety of treatment modalities to address these issues, including psychotropic medications and psychotherapy.

Psychotropic and related medications carry risks, including potentially serious adverse effects. Prior to prescribing any medication and throughout your care, your provider will discuss the risks and benefits of each medication, indications for use, interactions, adverse effects, alternatives, and your rights as a client. You will also have the chance to ask any questions.

Successful treatment requires active effort on your part, involving work on the discussed topics both during sessions and at home. Clients may discover aspects of themselves that they find challenging during appointments. Often, growth involves confronting and experiencing past issues, which can lead to distressing feelings such as sadness and anxiety. The success of treatment depends on the efforts of both the provider and the client, as well as the understanding that clients are responsible for the lifestyle choices and changes that may result from treatment.

Your provider will conduct an initial evaluation to determine if they are the best person to help you achieve your treatment goals. If it is determined that another practitioner would be better suited to meet your needs, we will provide you with appropriate referrals. Should you have any questions about your provider's techniques, you are encouraged to discuss them at any time.

CLIENT RIGHTS

- Be treated with dignity and respect.
- Know the qualifications and professional experience of your provider.
- Privacy and confidentiality per applicable laws and ethical codes.
- Ask questions regarding your treatment.
- Know information regarding diagnosis, treatment philosophy, method, progress, prognosis, and theoretical approach.
- Participate in decisions regarding your treatment.
- Know assessment results and have them explained to you in a manner that you understand.
- Refuse treatment methods or recommendations.
- End services at any time (please discuss the reason for wanting to end services).

CLIENT RESPONSIBILITIES

- Maintain your own personal health and safety.
- Take an active role in the therapeutic process, including honestly sharing thoughts, feelings, and concerns.
- Help plan your goals.
- Follow through with agreed-upon goals and treatment plan.
- Provide accurate and honest information regarding your past and present physical and mental health history, current symptoms, and treatment.
- Provide your practitioner with an up-to-date medication list and any changes at each visit.
- Keep scheduled appointments.

4. TELEHEALTH CONSENT

TELEHEALTH DEFINED: Telehealth means the remote delivery of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology may include audio and/or video-capable devices and/or services, internet and/or phone service, Bluetooth, and physical devices such as a cellphone, tablet, laptop, PC desktop system, or other electronic means.

Telepsychiatry provides psychiatric services using interactive video conferencing tools, like Skype (but more secure and HIPAA compliant), in which the provider and the patient are not at the same location. Telepsychiatry will allow the patient to receive mental health care without the need to visit the office and travel long distances.

LIMITATIONS OF TELEHEALTH SERVICES: While telehealth offers several advantages such as convenience and easier access to care, it is an alternative treatment delivery system and thus may involve disadvantages and limitations. Potential risks include but may not be limited to:

- Information transmitted may not be sufficient (poor resolution of video). For example, there may be a disruption to the service (e.g., the phone gets cut off or the video connection drops). This can be frustrating and interrupt the normal flow of personal interaction.
- There is a risk of misunderstanding one another when communication lacks visual or auditory cues. Your provider might not hear differences in your tone of voice that could easily be picked up if services were in person.
- Delays in medical evaluation and treatment due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy.
- A lack of access to all the information available during a face-to-face visit may result in errors in medical judgment (i.e. Inability to perform full physical exam and measure vital signs).
- May increase the likelihood of interruptions as telehealth may lack the space needed to ensure a quiet environment.

We will take every precaution possible to ensure technologically secure and private sessions. Alternatives to telepsychiatry include traditional face-to-face sessions.

IN CASE OF TECHNOLOGY FAILURE: During a telehealth session, we may encounter a technological failure or difficulties with hardware, software, equipment, and/or services supplied by a third party that may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please send us a message in your secure portal, call or text us at (480) 913-5872, or email us at Frontoffice@cactusgardenmhs.com. We will also attempt to reach you. It may be necessary to reschedule if there are problems with connectivity.

YOUR RIGHTS

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
- I understand that the software being used (Charm Telehealth, Spruce Health, and/or Zoom) are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. You can review the security features of Charm Health, Spruce Health and/or Zoom at:
    - https:// https://help.sprucehealth.com/article/481-spruce-app-patient
    - https://explore.zoom.us/en/trust/resources/
- I have the right to withdraw my consent to the use of telepsychiatry during my care at any time.
- I understand that my provider has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time.
- I understand that all rules and regulations which apply to the practice of nursing in the State of Arizona also apply to telepsychiatry.

YOUR RESPONSIBILITIES

- I will not record any telepsychiatry sessions without the prior written consent of my provider and I understand that my provider will not record telepsychiatry sessions without my consent.

- I will inform my provider if any other person can hear or see any part of our session before the session begins. Likewise, my provider will inform me if any other person can hear or see any part of the session before the session begins. This is so that your privacy can be protected.
- I understand that I MUST be physically present in the state of Arizona to be eligible for telepsychiatry services from my provider.
- The virtual sessions must be conducted on a reliable Wi-Fi network or device with strong service for the best connectivity and to minimize disruption.
- It is strongly suggested that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).
- Do not use "auto-remember" names and passwords.
- As the client, you are responsible for finding a private, quiet location where the sessions may be conducted.

IDENTITY AND LOCATION: We are required to verify your identity and location at the start of each session in case of an emergency and to ensure eligibility for telehealth services. Please immediately notify our practice of any changes to your current contact information.

5. USE OF AI SCRIBE SERVICE DURING VISITS

At Cactus Garden Mental Health Services, LLC, we may utilize an AI Scribe Service during visits to assist in clinical documentation. The AI scribe software transcribes and summarizes clinical encounters in real time, helping your provider create accurate and efficient progress notes.

POTENTIAL BENEFITS OF AI SCRIBE USE:

- Enhanced accuracy and completeness in documentation.
- Improved time management, allowing your provider to spend more time focused on you.
- Reduction of clerical burden, potentially leading to improved care quality.

POTENTIAL RISKS OF AI SCRIBE USE:

- While the system is HIPAA-compliant and encrypted, all digital tools carry a small risk of data breaches or misinterpretation.
- As with any transcription tool, there is a small chance of incorrect or incomplete information being recorded.

YOUR RIGHTS REGARDING AI SCRIBE USE:

- You have the right to opt out of the AI Scribe Service at any time by informing your provider at the beginning of your visit or by emailing us at Frontoffice@cactusgardenmhs.com.
- Opting out will NOT affect the care you receive or your eligibility to receive services from our practice.
- Your provider will instead document the session manually if you choose to opt out.

We are committed to maintaining your privacy and autonomy in all aspects of your care. If you have questions about the AI Scribe Service or how your data is handled, please reach out to our office.

6. BILLING, PAYMENT AND INSURANCE

PROFESSIONAL FEES: Psychiatric Evaluations (up to 90 minutes) are $220.00, and Medication Management follow-up appointments (up to 30 minutes) are $130.00. There is an extra $25.00 fee for all appointments not paid by 11:59 p.m. on the day of service. If your appointment exceeds the usual time, you will be charged in increments of 15 minutes at a rate of $65.00. In addition to scheduled appointments, we charge this same prorated rate for other professional services you may need. Other professional services include, but are not limited to, report writing, telephone consultations, virtual or telephonic attendance at meetings with other professionals you have authorized (excluding legal services), and the time spent performing any other service you may request of us. Any professional services requiring in person attendance is charged at an hourly rate of $300 plus the cost of total round-trip mileage at the most current mileage reimbursement rate for the state of Arizona, or actual transportation costs if travel requires means other than a vehicle. Basic forms and other routine paperwork not requested during an appointment time or exceeding 3 pages, but less than 10 pages are charged at a flat rate of $30.00. Each additional page is charged at a flat rate of $5.00 per page.

Any balance on your account must be paid in full prior to conducting your next scheduled appointment. If your balance is not paid in full at least 24 hours prior to your next scheduled appointment, your visit will be cancelled, and you may re- schedule once your balance is paid in full. Medication refills will not be provided if you have not been seen within the required follow-up time, regardless of reason.

**The above stated Professional Fees Policy may not apply if your health insurance plan covers the specified services, or if your insurance plan does not permit such charges.*

LEGAL FEES: Although it is our goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. If you become involved in legal proceedings that require our participation, you will be expected to pay for any professional time we spend on your legal matter, even if the request comes from another party. The hourly rate for legal services is $300.00. If travel is required to attend an in-person proceeding, or any other event related to a legal matter, you will be expected to pay the cost of total round-trip mileage at the most current mileage reimbursement rate for the state of Arizona, or actual transportation costs if travel requires means other than a vehicle.

PAYMENTS: You will be expected to pay for each appointment at the time it is held unless we agree otherwise or unless you have insurance coverage that requires another arrangement. There is an extra $25.00 fee for all appointments not paid by 11:59 p.m. on the day of service (applies to self-pay clients and co-payments or deductibles if using health insurance). Accounts over 30 days (about 4 and a half weeks) of the first mailed statement will accrue a finance charge of 1.5% per month or 18% per year. If your account has not been paid for over 60 days (about 2 months) and arrangements for payment have not been agreed upon, we may use legal means to secure the payment and a finance charge at the rate of 2% per month or 24% per year may apply. This process may involve hiring a collection agency or going through a small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information we will release regarding a client's treatment is their name, the dates, times, and nature of services provided, and the amount due.

Cactus Garden Mental Health Services LLC policy is to collect all payments or insurance information when services are rendered. For your convenience, we accept credit cards through our secure billing platforms, Bluefin via Charm Health, Headway, Sondermind and Alma (We may also use other third-party secure payment processing services for payment). Payments are subject to the terms and conditions of the third- party vendor (i.e. Bluefin via Charm Health, Headway, Sondermind or Alma may require a credit card on file to utilize their platform for services). We will bill all insurance companies that we are contracted with. Billing may be handled by a third-party service, including Charm Health, Elite Physician Services, Ryan Receivables, Headway, Sondermind, Alma or other billing companies.

HEALTH INSURANCE: Health insurance is a contract between you and your insurance provider. Your policy may or may not cover claims made by this office, and some services provided by our providers may be covered at different plan benefit levels. Claims may not be submitted with different codes if they have been denied due to lack of coverage.

You are responsible for verifying coverage and benefits for mental health services with your insurance company before your first office visit and for knowing the limits and exclusions of your insurance coverage. We submit insurance claims as a courtesy to our clients; all charges and outstanding balances are ultimately your responsibility. There is an extra $25.00 fee for all co-payments and deductibles not paid by 11:59 p.m. on the day of service (Only applies if your co-pay or deductible is known at the time of appointment). Any balance on your account must be paid in full prior to conducting your next scheduled appointment. If your balance is not paid in full at least 24 hours prior to your next scheduled appointment, your visit will be cancelled, and you may re-schedule once your balance is paid in full. Medication refills will not be provided if you have not been seen within the required follow-up time, regardless of reason.

Should you elect to utilize health insurance for services received, be aware that often insurance and managed care companies require information regarding diagnosis, symptoms, treatment goals, and prognosis about the insured before reimbursement is considered. Such companies may also request a copy of your records. When utilizing faxes, electronic communication devices, and web-based records management systems, there is always a level of vulnerability that may not be preventable despite all safeguards that have been put in place.

Cactus Garden Mental Health Services LLC does not service cases related to workers compensation or auto injury

claims.

**The above stated Health Insurance Policy and Fees may not apply if your health insurance plan covers the specified services, or if your insurance plan does not permit such charges.*

7. OFFICE POLICIES

CANCELLATION AND LATE POLICY: Please provide us with at least one full business day of notice to cancel or reschedule an existing appointment to avoid a cancellation fee (Example: A Monday morning appointment must be canceled by Friday morning). Cancellations with less than one full business days' notice, or arrivals (virtual or in person) greater than 10 minutes after your scheduled appointment time will be charged a fee of $50.00. If you are more than 10 minutes late for your scheduled appointment time, you will have to reschedule for the next available opening. Your appointment time will not be extended if you are late. We understand that circumstances beyond your control can arise. In specific cases, the fee may be waived at our discretion up to one time. Excessive lateness and missed appointments, whether paid or unpaid, may result in a re-evaluation of our contract and your continuation of treatment with our practice. Medication refills will not be provided if you have not been seen within the required follow-up time frame from your last appointment, regardless of reason. Please note that consistency and engagement will provide you with the optimum potential to benefit from your treatment plan. *The above stated Cancellation Policy may not apply if your health insurance plan covers the specified charges, or if your insurance plan does not permit such charges.

CONFIDENTIALITY: Discussions between a provider and a client are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include, but are not limited to, the following situations (which can vary by state):

- Abuse and neglect of children and vulnerable adults: If a client states or suggests that they are abusing a child (or vulnerable adult) or have recently abused a child (or vulnerable adult) or a child (or vulnerable adult) is in danger of abuse, it is required to be reported to the appropriate social service and/or legal authorities.
- Danger to self or others: When a client discloses an intention and/or a plan to harm another person, it is required to warn the intended victim and report this information to legal authorities. In cases where the client discloses or implies suicide intent and/or plan, it is required to notify legal authorities and make reasonable attempts to notify the client's family.
- Court orders: Health care professionals may be required to release records of clients if ordered by the court.
- Maternal exposure to controlled substances: Health care professionals must report admitted prenatal exposure to controlled substances that are potentially harmful.
- Client's death: In the event of a client's death, medical records may be disclosed to the medical examiner, parent(s), or legal guardian(s) of a deceased minor.
- Minors/Guardianship: Parent(s) or legal guardian(s) have the right to access the minor's records unless the provider believes that sharing this information will be harmful to the client.
- Professional misconduct: Other health care professionals must report professional misconduct by another health care professional. In cases where a health care professional or legal disciplinary meeting is held regarding their actions, related records may be released to substantiate disciplinary concerns.
- Other provisions: Client information may be disclosed in consultations with other practitioners/professionals to provide the best possible care. In such cases, the name of the client or any identifying information is not disclosed. Clinical information about the client is discussed.

CONTACTING US: Please note that we are not immediately available by telephone and calls are automatically routed to voicemail. Missed calls without a voice message will not be returned. The quickest way to get in touch with us is by sending a secure message through your Charm Health portal or text messaging our Charm Health client support line at (623) 887-6164. You may also text us at (480) 913-5872 if you do not have access to your portal. By initiating a text message with us, it is implied that you understand and agree to our electronic communications consent form. We strive to respond to all communications within one business day; however, please allow up to two business days for a reply. Please visit our website at www.cactusgardenmhs.com for more information on communicating with our practice.

MEDICAL RECORDS: To request medical records, please email us at Frontoffice@cactusgardenmhs.com or message us through your secure Charm Health portal. A completed ROI by the client or legal guardian is required to release any medical records. Please allow up to five business days for processing.

EMERGENCIES OR CRISES: Cactus Garden Mental Health Services LLC is not a crisis or emergency service. We check our missed phone calls, voicemails, text messages, emails, and faxes only during regular business hours. If you have a life-threatening emergency, immediately call 911 or go to your nearest emergency room. Your safety and well-being are our primary concerns. For mental health resources, including crisis lines, psychiatric urgent care, and inpatient facility information, please reach out to the 24/7 National Suicide and Crisis Lifeline by calling or texting 988. For the Poison Control Center, please contact 1-800-222-1222.

If we become concerned about your well-being, lose contact with you, or you fail to attend a scheduled telehealth appointment, we will reach out to you via phone or other authorized contact method to ensure your safety. Additionally, should there be indications of a significant issue or crisis, we request your consent to contact a designated individual to ensure your safety. Therefore, we ask that you provide emergency contact information as part of your participation in our telehealth services. If we are unable to reach you or your emergency contact, and there is a continued concern for your safety or well-being, we may contact 911 or your local police department to initiate a welfare check.

**By providing us with your emergency contact information, you grant us permission to contact them for any of the reasons listed above.*

8. ACKNOWLEDGEMENTS

Please read the following information in its entirety

- I have been provided with the HIPAA Notice of Privacy Policy. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices regarding protected health information. If you have any objections to this form, please ask to speak with our staff members in person or by phone on our main phone number.
- I understand that telehealth involves the communication of my mental health information in an electronic or technology-assisted format.
- I understand that telehealth services can only be provided to clients, including myself, who are physically located in the state of Arizona at the time of this service.
- I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, Medicaid, or self-pay rates and it is my responsibility to check with my insurance plan to determine coverage.
- I understand that all electronic communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
    - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
    - Electronic systems accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
    - Despite reasonable efforts on the part of my provider, the transmission of mental health information could be disrupted or distorted by technical failures.
- I agree that the information exchanged during my telehealth visit will be maintained by the providers involved in my care.
- I understand that information, including mental health records, is governed by federal and state laws that apply to telehealth. This includes my right to access my own records (and copies of my records).
- I understand that Cactus Garden Mental Health Services, LLC may obtain my personal health records and/or relevant medical data from third party services deemed necessary to provide safe and high-quality care. Examples of such services include Sonora Quest Labs, Lab Corp Labs, Simon Med Imaging, Arizona Health Information Exchange and Sure Scripts prescription history.
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location.
- Cactus Garden Mental Health Services, LLC and its staff, including your provider, are not responsible for breaches of confidentiality caused by an independent third party or by me.
- I agree that I have verified my identity and current location with my provider in connection with the telehealth

services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

- I understand that I have a responsibility to verify the identity and credentials of the provider rendering my care via telehealth and to confirm that they are my provider.
- I understand that electronic communication cannot be used for emergencies or time- sensitive matters.
- I understand and agree that receiving mental health care via telehealth may limit my provider's ability to fully care for my needs. As the client, I agree to accept responsibility for following my provider's recommendations, including further in-person assessment, testing, or office visits.
- I understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.
- I understand that my provider may need to forward my information to an authorized third party with my consent. Therefore, I have informed the provider of any information I do not wish to be transmitted through electronic communications.
- I understand the inherent risks of errors or deficiencies in the electronic transmission of mental health information during telehealth visits.
- I understand that Zoom, Spruce Health, Microsoft products, SMS messaging and similar services may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.
- To the extent permitted by law, I agree to waive and release my provider and their institution or practice from any claims I may have about the telehealth visit.
- I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office and to the existing emergency 911 services in my community.
- I agree to receive important communications regarding my personal health and treatment, and Cactus Garden Mental Health Services, LLC via the following methods:
    - Phone (even if it may not be encrypted)
    - SMS/Text (even if it may not be encrypted)
    - Email (even if it may not be encrypted)
    - Spruce Health Secure Messaging System
    - Charm Health Secure Portal
    - Voice Mail (even if it may not be encrypted)
    - Regular mail

Please note that sending an email or SMS text with health-related information to staff at our practice implies you give consent to receive such correspondence.

You may opt out from any of the communication methods offered by Cactus Garden Mental Health Services, LLC at any time by notifying our office via email (Send to: Frontoffice@cactusgardenmhs.com).

9. MEDICATION CONSENT

I will have the opportunity to discuss the following information about each medication prescribed to me with my Behavioral Health Medical Practitioner:

- The diagnosis and target symptoms for the medication recommended;
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects, including medication interactions and risks of medication to pregnant people and people who are chest feeding;
- The possible alternatives;
- The possible results of not taking the recommended or prescribed medication(s);
- My right to actively participate in my treatment by discussing medication questions or concerns with my Behavioral Health Medical Practitioner;
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment is required under a Court Order or in a Special Treatment Plan);
- Food and Drug Administration status of the medication(s) for persons under 18 years of age and the level of evidence supporting the recommended medication(s);
- Potentially life-threatening side-effects of each medication. I will have ample opportunity to ask any questions

that I may have to understand the potential risks involved with each medication prescribed and agree to seek immediate medical care should I experience any of the life-threatening side-effects discussed;

- I understand that the dosage of my medication(s) may need to be adjusted during the course of treatment, and this consent form covers all possible dose ranges of the prescribed medication(s);
- I understand that the medication(s) being prescribed may be used "off-label" to treat symptoms that the medication(s) is not approved for by the Food and Drug Administration. I will have an opportunity to ask any questions that I may have;
- I understand that it is my responsibility to inform my healthcare provider of any questions or concerns that may arise throughout the course of treatment, including any side-effects that may develop because of the prescribed medication(s). I also understand that it is my responsibility to inform all my healthcare providers of my most current medications and treatments;
- I agree not to combine my medication(s) with illicit substances (alcohol, marijuana, methamphetamine/amphetamines, opioids, other stimulants or central nervous system depressants, etc.), supplements, vitamins, other drugs or substances not previously discussed and approved by my healthcare provider. I understand that such combinations may have potentially life-threatening interactions and effects on my body and health.

I have read, understand and agree with the above information in this Medication Consent Form.

I understand that it is my right and responsibility to ask any questions and inform my provider and Cactus Garden Mental Health Services, LLC immediately if any of the information listed in this consent form is unclear, or not satisfactorily explained to me.

10. CONTROLLED SUBSTANCE AGREEMENT

Cactus Garden Mental Health Services, LLC does not prescribe, taper or continue existing prescriptions for Benzodiazepines. We are happy to discuss alternative options with you. Please reach out to us if you have any questions or concerns.

***Stopping Benzodiazepines abruptly and without a safe taper plan can result in serious and life-threatening adverse effects. Please discuss with your current prescriber prior to making any changes to your existing Benzodiazepine regimen.*

I understand that to receive care for the treatment of my diagnosis with the use of controlled medications, I agree to and will comply with the following information listed on this form.

A. MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT: A mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with the undersigned provider.

B. USE OF MEDICATIONS: I will take all medications as prescribed. I will speak with the undersigned provider before making any change in either the dose or frequency of my medications. There will be no early refills of controlled medications without prior authorization. Controlled medications must all be obtained from the same pharmacy each time (any exception must be approved by the undersigned provider). I will abstain from alcohol and other illicit drug use. If I am found to be taking medication other than how it is prescribed, I understand that my provider may cancel the prescription, refuse to refill prescriptions, and/or titrate dose of medications.

C. SEEKING PRESCRIPTIONS: I will neither seek nor fill prescriptions for any controlled medication from any other health care provider unless authorized by the undersigned provider. I will not harass or repeatedly speak with the pharmacist about refills which may be early. I will not call the provider after hours about my controlled substance prescription refills.

D. MEDICAL RECORDS RELEASES: I will inform all my health care providers that I receive controlled substance(s) and will maintain an unrestricted and current medical records release on file.

E. DRUG SCREENING: I will participate in drug screening as a part of my treatment plan. I understand that drug screening may be conducted at least every 12 months and may be required more frequently at the discretion of

the undersigned provider. Screening may include urinalysis, blood testing or pill counts. I agree to pay all costs associated with drug testing not covered by my insurance. Refusal to submit to screening at the time specified may result in termination of services.

F. ILLEGAL AND NON-PRESCRIBED DRUG USE: I understand that the use of any controlled medication not prescribed by the undersigned provider may result in termination of care. I authorize the practice to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of controlled medicines. I authorize the practice to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also understand that the use of any illegal substance, including marijuana, may result in termination of care.

G. LOST OR STOLEN MEDICATIONS: I agree to safeguard all medications prescribed by the undersigned provider and understand that lost or damaged medications will not be replaced.

H. PRESCRIPTIONS WHILE TRAVELING: The practice may provide prescriptions for up to 90 days when patients are traveling out of state (if allowed by state/federal law and at the discretion of the provider). Patients will have to arrange for shipment of controlled substances by their pharmacy at their own expense. Patients who will be out of state for longer than 90 days need to arrange for health care at their travel destinations.

I. DRIVING & OPERATING EQUIPMENT: Many medications can cause drowsiness and/or a very relaxed state of mind causing the operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel drowsy.

J. OTHER RESTRICTIONS AND/OR CONSIDERATIONS: My provider may request I obtain lab and/or diagnostic testing, including, but not limited to, electrocardiogram (ECG), blood work, and vital signs (blood pressure, heart rate, pulse oximetry, respirations, temperature, height and/or weight) prior to, and throughout treatment with a controlled substance. Some or all these tests may need to be performed by a trained medical professional at my expense. It is my responsibility to obtain and provide my healthcare provider with an accurate recording of such tests and pay any expenses that may arise. I will inform my healthcare provider immediately if I have any issues or concerns completing these requirements. My provider may discontinue or titrate doses of medications at any time if my lab and/or diagnostic values are out of the normal range.

K. TERMINATION: I will no longer be eligible for care if I am in possession of, or use illicit drugs or substances, trafficking in controlled or illegal substances, intoxicated or if arrested for DUI. If I alter my prescription in any way, sell or share my medications, I will no longer be eligible for care.

I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE.

11. HEALTHCURRENT HIE PART I

healthcurrent

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors can access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Radiology reports
- Medical history
- Clinic and doctor visit information
- Medications
- Health plan enrollment and eligibility
- Allergies
- Lab test results
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your

health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases.

One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.

   CAUTION: If you opt out, your health information will NOT be available to your healthcare providers —even in an emergency.

2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.

3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

   IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

12. HEALTHCURRENT HIE PART II (OPTIONAL)

healthcurrent

CONSENT TO RELEASE BEHAVIORAL HEALTH & SUBSTANCE ABUSE INFORMATION

(FOR TREATING PROVIDERS)

Patient Name: _____

Date of Birth: _____

By signing this form, I permit all of my past, present and future healthcare providers where I have received behavioral health treatment, including any treatment for substance use disorders, to release my information to Health Current, the statewide health information exchange (HIE), and to the organization listed here:

Name of Healthcare Organization with a Treatment Relationship: CACTUS GARDEN MENTAL HEALTH SERVICES, LLC

Phone Number
(480) 913-5872

Address
7165 E UNIVERSITY DR
BUILDING 14, SUITE 155

City
MESA

State
AZ

Zip Code
85207

I am receiving (or will receive) treatment from this organization. The purpose of this disclosure is for:

*My treatment;
*Payment for my treatment (for example, billing insurance companies); and
*Healthcare operations activities (for example, improving the quality of care for patients, managing the care of patients, patient safety activities, and other activities necessary to run a health care organization).

I authorize the disclosure of all my medical information for these purposes, including behavioral health information and substance use disorder information (e.g., drugs and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health, communicable disease related information, and HIV/AIDS-related information.

I understand that the organization listed above will obtain this information about me through Health Current, the statewide HIE. I understand that if I previously opted out of having my health information shared through the HIE, this form will change that decision. I understand that if I sign this form, I agree to have my health information shared through the HIE. I understand that I can change this decision at any time.

I understand that I may take back or cancel this consent to share my information at any time, except where someone already relied on my consent to release the information. If I want to cancel my consent or if I have questions, I will contact the organization at the contact information listed above. Unless I cancel this consent earlier, it will automatically terminate one year from the date of my signature. I understand that my substance use disorder treatment information

will continue to be protected by federal law after it is released.

Signature of Patient: _____

Date**:** _____

Signature of Parent/Guardian (If Patient is a child under the age of 18) * *Both the child and parent/guardian must consent to disclosure of the child's substance use disorder information, unless the child is married, homeless, or emancipated.

Signature: _____

Date**:** _____

Signature of Patient's Healthcare Decision Maker (If Patient has been declared incompetent by a court or is deceased)

Signature: _____

Date: _____

Notice to Recipient of Substance Use Disorder Information: 42 CFR part 2 prohibits unauthorized disclosure of these records.

13. CONSENT TO TREATMENT

SECTION A

- I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed by discussing the potential benefits, risks and hazards involved.
- I hereby request and consent to examination and treatment with a psychiatric mental health nurse practitioner or other provider employed by or providing services on behalf of Cactus Garden Mental Health Services, LLC.
- I give my oral and written consent to the evaluation, assessment, and treatment to cover the entire course of treatment and/or services for my present condition and any future conditions for which I seek treatment. I authorize my provider to provide such care, treatment, or services as are considered necessary and advisable. Signing this document indicates that you understand and agree that you will participate in the planning of your care, treatment, and services, and that you may stop such care, treatment, or services at any time.

SECTION B

I acknowledge receipt of, have read, and fully understand all sections 1 through 13 outlined below and in the Cactus Garden Mental Health Services, LLC New Client Paperwork. I agree to comply with all aspects of the information provided.

1. HIPAA NOTICE OF PRIVACY POLICY
2. INFORMED CONSENT
3. CLIENT SERVICES, RIGHTS, AND RESPONSIBILITIES
4. TELEHEALTH CONSENT
5. USE OF AI SCRIBE SERVICE DURING VISITS
6. BILLING, PAYMENT, AND INSURANCE
7. OFFICE POLICIES
8. ACKNOWLEDGEMENTS
9. MEDICATION CONSENT
10. CONTROLLED SUBSTANCE AGREEMENT
11. HEALTHCURRENT HIE NOTICE OF HEALTH INFORMATION PRACTICES
12. OPTIONAL HEALTHCURRENT HIE CONSENT TO RELEASE BEHAVIORAL HEALTH & SUBSTANCE ABUSE INFORMATION
13. CONSENT TO TREATMENT

By signing and submitting this form I acknowledge that I have been provided with an ample opportunity to read the entire Cactus Garden Mental Health Services, LLC New Client Paperwork or that it has been read to me.

SECTION C:

HEALTHCURRENT HIE PART I:

- I acknowledge that I have received, read, and understand the NOTICE OF HEALTH INFORMATION PRACTICES (Section 11).
- I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider. *

HEALTHCURRENT HIE PART II:

- I have received, read and understand the HEALTHCURRENT HIE PART II CONSENT TO RELEASE BEHAVIORAL HEALTH & SUBSTANCE ABUSE INFORMATION FORM (Section 12). I understand that this form is optional and must be completed and signed to be valid.

Information on the Arizona Health Information Exchange can be found at: https://contexture.org/patient-rights/

You may also contact our office should you have any questions or concerns, or to request an opt-out form.

ACKNOWLEDGEMENT AND SIGNATURE

I have carefully read and fully understand all the information provided in sections A, B, and C of the Consent to Treatment form, and I agree to the terms outlined therein.

Yes No

Today's Date: _____

Client Full Name (Must match name on driver's license or state ID): _____

Legal Guardian Full Name (If applicable): _____

Client Signature (Must be legal guardian signature if applicable): _____

Thank you for completing the requested forms. We look forward to seeing you soon!