Client Full Name: Jane Q Doe, Jr.
AHCCCS ID #: 123456A

Living and Balance Wellness Center

10000 N 31st Ave, Phoenix, AZ 85051-9620
602-314-6312 602-926-8317
www.livingandbalance.com

Demographics

Services Interested in Receiving:

☐ In-Home Skills Training (Behavior Coaching)	☐ Individual/Group Counseling (School-Based/Family/Couples/Marriage)
☐ Skills Training and Development Group Programs (Spark/After School/DV/Parents)	☐ In-School Skills Training (Behavior Coaching)
☐ Case Management (Care Coordination and Family Engagement)	☐ IOP Groups
☐ Psychiatric Diagnostic Evaluation	☐ Other
☐ Medication Management	

Location of Services: 11 Office

Client First Name: Jane	**Client Last Name:** Doe
Client Preferred Name: Janey	**Client Date of Birth:** 11/19/1985
Client Gender: Female	**Client Preferred Pronouns:** She/Her/Hers
Legal Guardian/ Parent First & Last Name if Applicable:	

Relationship to Client:

Client Address: 12345 E Lakeside Dr. Unit 100
Anytown, CO 12345

Is this address is a Behavioral Health Residential Facility or other treatment center?

Client Phone Number: 555-555-1111

Guardian Phone Number if applicable:

Type of Phone Number:

May we leave a message:

LBWC Demographics

Client email address: jane.doe@email.com

May we email to you and receive emails from you:

Ethnicity:

Race:

Religious or spiritual beliefs:

Marital status: Widowed **Employment Status:** Employed Full-Time

Medication/Allergy Information

Active Medications

Medication	Dosage	Directions	Prescribing Doctor	Start Date	Stop Date	Qty

Reason for Choosing us

How did you find out about us?

Reasons for Seeking Help:

What are the reasons for your visit today?

How intense is your emotional distress? (Where 0 is not at all and 10 is incapacitating.)

To what degree do your problems affect your ability to perform at work, at home, and in your relationships with others? (Where 0 is not at all and 10 is incapacitating.)

When did these problems begin, and what was happening in your life at that time?

Psychiatric and Medical History

Have you been diagnosed with any psychiatric or mental health problems?

Please explain:

Have you been diagnosed with any physical health problems?

Please explain:

Are you on any medication, and what for?

Please provide the name of your family doctor and their contact details:

Please provide the name of your psychiatrist (if you have one) and contact details:

Name of Pharmacy you use:

Pharmacy Address

Pharmacy Phone

Treatment goals

What motivated you to come here today?

What are your goals for treatment?

Is there anything else that you would like to mention?

Insurance Information

Are you using:

Are you the primary insured?

If you are not the primary insured, please state the name of the primary insured and your relationship with them.

Name:		Relationship to Client:	

Primary Insured Date of Birth:	

Health insurance plan name (primary). If you are using EAP state the EAP plan. (If applicable)

Plan Member ID (primary). If you are using EAP state the EAP authorization number. (If applicable)

Plan Group ID (primary). If you are using EAP state your employer's company name. (If applicable)

Health insurance plan name (secondary if applicable)

Plan Member ID (secondary if applicable)

Plan Group ID (secondary if applicable)

Do you agree and consent to Living and Balance Wellness Center billing your above stated health plan for services? If you are choosing the self-pay option, please state self-pay in this section.*

Guardian Information

Do you have a guardian or power of attorney? (yes or no). If a guardian is completing for their minor child or dependent adult select yes.*

If yes, please provide the name of your guardian or power of attorney:

Do you have a Healthcare Advance Directive?	
Do you have a Mental Health Advance Directive?	

Emergency Contact

Do you have an emergency contact you would like to keep on file with us?

If yes, please provide their name, relationship to you, and their best contact information for them. By filling this section out you agree for Living and Balance Wellness Center to contact your emergency contact if there is an emergency.

Emergency Contact Name

First Name:	
Last Name:	
Relationship:	
Best Contact:	

Client/Parent/Guardian Signature: Date:

Client Name: Jane Q Doe, Jr.

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Consent for Service/ General Consent

All Living and Balance Wellness Center services are confidential processes designed to help clients address behavioral and mental health concerns and teach methods to better understand themselves. Services that teach clients effective basic living skills, psych-social rehabilitation, and coping strategies while building a relationship with providers and therapeutic staff. There may be periods of stress and anxiety while learning to implement strategies taught by providers into the client's current lifestyle. All providers are licensed in the state of Arizona or practicing in the state of Arizona and are supervised by a licensed clinical supervisor licensed by the state of Arizona. Even if you are visiting another state or country, the Living and Balance Wellness Center remains under the rules, regulations, standards, and laws of Arizona. Therefore, all Living and Balance Wellness Center providers may only provide services to clients residing and physically located in Arizona. LBWC Providers are available to assist and support you throughout the identified services.

- I agree and give permission to participate in Living and Balance Wellness Center services and assistance.
- I understand that others may be involved in the treatment plan and the release of information must be obtained.
- I agree to participate in the activities to be carried out to resolve and improve functioning.
- I have read and discussed the above information with my providers.
- I understand the risks and benefits of services, the nature of limits and confidentiality, and what is expected of a client of Living and Balance Wellness Center.
- I understand that I must reside and be physically located within the state of Arizona to receive services from Living and Balance Wellness Center.
- I understand that I may withdraw my consent to release and to participate with Living and Balance Wellness Center at any time.

Emergency
If an emergency, please call 911 or EMPACT-SPC crisis line at 480-784-1500. This crisis line is available 24-hours a day, 7 days a week.

Client Records
All of your information is stored within a HIPAA compliant electronic medical records forum. Living and Balance Wellness Center will save your chart for up to 7 years following the closure of chart for services. At any time, you have a right to your records. If you are requesting your records, please allow up to 14 days from the medical records department. You may complete a record request by contacting our office and requesting one be sent to you to complete.

Records Sharing
Your record is only shared with those you provide a release of information for. In some cases, there are court orders that require sharing of records. If one or both of these scenarios are not present then your records are not shared with anyone outside of Living and Balance Wellness Center practice. You are also authorizing the release of information about your care to your insurance company. The information often required by insurance companies may include, but is not limited to, diagnosis, prognosis, and treatment goals. It is important for you to understand that your insurance company has the right to your records for the purpose of verifying the billed services. As a treatment team, all of Living and Balance Wellness Center employees have access to your record. We also will frequently speak specifically about the care of clients in a treatment team setting. You have a right to ask what if anything was shared about you in these settings. We only share that information that is pertinent to client care.

Guardian Expectation
For guardians completing this form with or for your minor child or adult dependent. You agree that you will allow treatment to take place for your dependent with some privacy. As guardian, you have full access to request records from Living and Balance Wellness Center at any time by signing a release of information for how you choose to have them released to you. In counseling it is important even for dependents to feel they have privacy in the session to share. Sharing is very important to the outcome of treatment. For this reason, we ask that guardians allow privacy. Clinicians at Living and Balance Wellness Center agrees that if a high-risk situation or emergency presents in session clinician will bring guardians into session to address with them. If clinician does not speak to guardians outside of the set timeframes, then it is to be realized that no crisis or high-risk situations have been shared. Further, it is expected that guardians will take an active role in the healing process their dependents are enrolled in for counseling. This means that engagement at intake and treatment plan updates at minimum is expected. As a client you have a right to participate in treatment decisions and in the development and periodic review and revision of the client's treatment plan.

Minors in Treatment

A legal guardian/adult must be present with minor client for services regardless if they are happening in a Living and Balance Wellness Center Office, telehealth, or in the community. A legal guardian would include parents, grandparent or any other adult such as aunt, uncle etc.that holds legal custody of the minor. Should the legal guardian not be present and an approved adult, identified by the legal guardian, needs to accompany the minor client this may occur ONLY if Living and Balance Wellness Center has a signed release of information authorization form the parents or legal guardian before the client is seen. NO verbal authorization will be allowed. Please contact us should you need access to a release of information authorization form. Legal Guardians who have minor clients receiving services in office are to sign in and sign out their minor client at the start and end of the session and remain available and on the premises should any provider questions or concerns arise while the client is in treatment.

Legal Guardians who have minor clients receiving services in the community must be present and or available throughout the duration of the services. Living and Balance Wellness Center staff members are prohibited from being the only adult in the home, if services are being provided at home, therefore at the time of services a guardian shall be readily and easily accessible throughout the duration of services.

Obtaining legal consent for child and adolescent psychiatric evaluations, medical, and counseling treatment.

Decisions about psychiatric, other behavioral health and medical care must be made by the child's legal guardian(s), who must be physically present to provide consent, have an opportunity to be fully informed of the evaluation process, be provided with an opportunity to ask questions, and in order for identity to be verified. In the situation of a parental separation or divorce (except in the case of one parent having sole physical and legal custody), both guardians have a right to consent and decline treatment and both parents are invited and encouraged (as they are able to) participate in the process of evaluation and treatment. If one parent retains sole physical and legal custody, this guardian MUST provide legal documentation of this in order for the psychiatric evaluation to occur as scheduled if the other guardian is declining services. Guardians have a legal right to medical records.

If services are being rendered to minors, please also provide with forms minor's birth certificate and parental ID to ensure the parents/guardians are requesting the services. If legal documents state one parent is sole guardian please provide these documents as well with enrollment forms.

Even in the case where one guardian has "final decision making" both guardians have a right to consent to treatment or deny treatment when on the court documents custody is granted to both guardians. Final decision making does not mean the guardian without final decision making is left out of treatment decisions.

At intake of a minor we will require:

- Guardian Drivers License
- Insurance Card
- Minor birth certificate
- Signed consents by at least one guardian

If there is legal court documentation signed by a judge that states specific treatment or custody arrangements that means one parent can be left out of treatment by the other parent copies of this documentation needs to be provided in its entirety.

If one guardian signs only and there is another legal guardian this guardian has a right to medical records if requested. Also either guardian can deny treatment at any time and determine length of treatment. If one guardian wants treatment and the other does not then treatment cannot start or continue, referrals will be offered, and treatment will pause or end.

Client/Parent/Guardian Signature: Date:

Client Name: Jane Q Doe, Jr.

Staff Signature: Date:

Staff Name: Dr. Bob Johnson, LPC

Completed in secure client portal.

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HIPAA Policy Agreement

Confidential Electronic Data Storage
Your confidentiality as a client is of utmost importance. Living and Balance Wellness Center is committed to protecting your Personal Health Information (PHI) and the following is a brief description of how your care team manages your personal health information per Federal and Arizona State Laws.

The following information is protected under this agreement:

- Personal information
- Medical Information
- Conversations between you and Living and Balance Wellness Center providers and staff. The following personnel will have access to your medical information:
- Providers (Doctors, Nurse Practitioners, Physician Assistants) that are employed or contracted with Living and Balance Wellness Center that are authorized to access or enter information in your file/chart.
- Medical Support Staff (Registered Nurses, Medical Assistants, Administrative Medical Assistants) that are employed or contracted with Living and Balance Wellness Center that are authorized to access or enter information in your file/chart.
- Any volunteer groups that are contracted to practice at Living and Balance Wellness Center (Students from contracted educational institutions and other organizations that have current contracts to assist at Living and Balance Wellness Center facilities).
- Hospitals and first responders that are needed for immediate emergency care.
- Living and Balance Wellness Center may also submit your medical information to your health insurance, as permitted by your health insurance, for remittance and claims. All Living and Balance Wellness Center facilities are in direct agreement to follow all Federal and State laws to protect your personal health information.
- Limited medical information may be shared to pharmacists, specialists and/or durable medical equipment companies to ensure that your care plan is fully coordinated.
- Living and Balance Wellness Center may also contact you by means of phone calls, e-mails and/or text messages to remind you of scheduled appointments. This process will only share your name and no personal health information.

YOUR RIGHTS:
Your right as a patient may request, in writing, restrictions on the use or sharing of any information, received confidential communication, inspect and receive copies of shared information, received an accounting of shared information and amend or revoke authorization; except in medical emergencies and in any case we suspect or are aware of harm to yourself and others.

A complete policy of our HIPAA practices may be requested and given to you or posted in the lobby.

Client/Parent/Guardian Signature: Date:

Client Name: Jane Q Doe, Jr.

Staff Signature: Date:

Staff Name: Dr. Bob Johnson, LPC

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Patient Rights

A. An administrator shall ensure that:
1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the hospital's premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures include:
    a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
    b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:
1. A patient is treated with dignity, respect, and consideration;
2. A patient is not subjected to:
    a. Abuse;
    b. Neglect;
    c. Exploitation;
    d. Coercion;
    e. Manipulation;
    f. Sexual abuse;
    g. Sexual assault;
    h. Seclusion, except as allowed under R9-10-217or R9-10-225;
    i. Restraint, if not necessary to prevent imminent harm to self or others or as allowed under R9-10-225;
    j. Retaliation for submitting a complaint to the Department or another entity; or
    k. Misappropriation of personal and private property by a hospital's medical staff, personnel members, employees, volunteers, or students; and
3. A patient or the patient's representative:
    a. Except in an emergency, either consents to or refuses treatment
    b. May refuse examination or withdraw consent for treatment before treatment is initiated;
    c. Is informed of:
        i. Except in an emergency, alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of the proposed psychotropic medication or surgical procedure;
        ii. How to obtain a schedule of hospital rates and charges required in A.R.S. § 36-436.01(B);
        iii. The patient complaint policies and procedures, including the telephone number of hospital personnel to contact about complaints, and the Department's telephone number if the hospital is unable to resolve the patient's complaint; and
        iv. Except as authorized by the Health Insurance Portability and Accountability Act of 1996, proposed involvement of the patient in research, experimentation, or education, if applicable;
    d. Except in an emergency, is provided a description of the health care directives policies and procedures:
        i. If an inpatient, at the time of admission; or
        ii. If an outpatient:
            1. Before any invasive procedure, except phlebotomy for obtaining blood for diagnostic purposes; or
            2. If the hospital services include a planned series of treatments, at the start of each series;
    e. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a hospital for identification and administrative purposes; and
    f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
        i. medical record, or
        ii. Financial records.

C. A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To have access to a telephone;

5. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
6. To receive a referral to another health care institution if the hospital is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
7. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
8. To participate or refuse to participate in research or experimental treatment; and
9. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.

Client/Parent/Guardian Signature: Date:

Client Name: Jane Q Doe, Jr.

Staff Signature: Date:

Staff Name: Dr. Bob Johnson, LPC

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Privacy Notice

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

I. **Living and Balance Wellness Center PLEDGE REGARDING HEALTH INFORMATION:**
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from our agency. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. We are required by law to:
- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

II. **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:**
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in the diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. **CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:**
- Psychotherapy Notes. We do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
  a. For our use in treating you.
  b. For our use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
  c. For our use in defending myself in legal proceedings instituted by you.
  d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
  e. Required by law and the use or disclosure is limited to the requirements of such law.
  f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
  g. Required by a coroner who is performing duties authorized by law.
  h. Required to help avert a serious threat to the health and safety of others.
- Marketing Purposes. As providers, we will not use or disclose your PHI for marketing purposes.
- Sale of PHI. As providers, we will not sell your PHI in the regular course of my business.

IV. **CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.**
Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

- When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
- For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
- For health oversight activities, including audits and investigations.
- For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
- For law enforcement purposes, including reporting crimes occurring on my premises.
- To coroners or medical examiners, when such individuals are performing duties authorized by law.
- For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
- Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
- For workers' compensation purposes. Although my preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.

10 Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with me. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. **CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.**

- Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. **YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:**

- The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if we believe it would affect your health care.
- The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
- The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
- The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.
- The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost based fee for each additional request.
- The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say "no" to your request, but we will tell you why in writing within 60 days of receiving your request.
- The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Client/Parent/Guardian Signature: Date:

Client Name: Jane Q Doe, Jr.

Staff Signature: Date:

Staff Name: Dr. Bob Johnson, LPC

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Media Release

I give Living and Balance Wellness Center media personnel permission to photograph myself/my youth	
I give Living and Balance Wellness Center media personnel permission to share photographs/videos of myself/my youth on community outreach pages such as Facebook, Twitter, and Instagram	
I understand there are no monetary gains associated with any photographs of myself/my youth.	

**Please note, if your youth is in foster care, we will need his/her DCS case manager to approve postings on social media. Please notify the office manager and he/she will send the form to the DCS case manager.

Notice of Security Cameras
I understand that Living and Balance Wellness Center facility has security cameras throughout the facility in the common areas for safety purposes. I understand these cameras can be reviewed by management personnel at any time.

By signing below, I affirm that I have been notified of the security cameras and their purpose as it pertains to this facility. I also affirm that I have answered the above questions regarding media release.

Client/Parent/Guardian Signature: Date:
Client Name: Jane Q Doe, Jr.

Staff Signature: Date:
Staff Name: Dr. Bob Johnson, LPC

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Clinical Supervisors and Supervisees - How to Contact Supervisors at Living and Balance Wellness Center

Each of the Clinical Supervisors are listed below:

- Lorain Moorehead LCSW-13748 lorain@livingandbalance.com

How to Contact Clinical Supervisors
When a counselor/social worker are associate licensed (LCSW/LAC) or license eligible (MSW, MA, MS, Clinical intern) they are clinically supervised by the clinical supervisor(s) listed above. If your insurance plan is contracted with a supervisor, certain insurance plans do allow for supervisor or incident to billing per CMS guidelines. Counselors and social workers will go over with you in session who their clinical supervisor is and how to contact their supervisor if needed to. Supervisors can all be contacted by calling also our front desk line at 602-314-6312 or emailing info@livingandbalance.com. If you are not sure who supervises your counselor social worker and would like to have that information also feel free to call or email and we will follow up with you. You can also find their above contact information to email them and contact office directly to speak to them.

Termination of Services
You may terminate services at any point. Should termination occur sooner than discussed, appropriate discussions with you about the termination process will occur. Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. When our work comes to a close, we ask that you schedule at least one final session in order to review the work you have done. Should you fail to schedule an appointment for three consecutive weeks, there is a pattern of attendance inconsistencies, unless other arrangements have been made in advance, for legal and ethical reasons, providers must consider the professional relationship to be discontinued. Occasionally, clients return to services to process new challenges. If you decide to return in the future, please know that Living and Balance Wellness Center has an open door policy and welcomes the possibility of working together again. However, it will be at your provider's clinical discretion and also dependent upon availability. If we are not able to see you immediately, we encourage you to contact your insurance provider for support and/or access www.psychologytoday.com.

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www.livingandbalance.com

No Show & Cancellation Policy

At Living and Balance Wellness Center we value our staff and clients alike. To attempt to reduce and eliminate no shows and late cancellations to occur we require a $25.00 fee to be paid in the event that a client or patient cancels their visit in 24 hours or less to the visit time/date or a no show occurs.

Two no shows without a call into our office within 24 hours of the missed visit will result in the you being removed from all visits going forward until you call our office to reschedule and pay your balance and/or fees associated with the no show.

If after discussing other options with you your attendance has not changed, we may need to discontinue your treatment. Should you become unresponsive you will be removed from your therapists scheduled and encouraged to reach out to the front office to be rescheduled. Please note that our front office will try to add you back to your therapist's schedule if possible but due to limited availability you may be rematched with a new therapist within the agency. Should you not engage in services within 14 days, you will be discharged from therapeutic service. Should you wish to engage in services after being discharged you will need to complete a new intake and sign updated consent forms.

If you are having difficulty getting to the visit or are going to be late please call us right away so we can help. If something last minute comes up and you need to cancel but can reschedule to a different time and/or day then do this also, which again will stop the late cancellation fee from happening. However, if you reschedule to another date/time of the cancellation week and no show or cancel the rescheduled visit a $25 fee applies even if the cancellation of the visit happened outside of 24 hours.

Group Therapy: Group therapy runs in at least 6-10 week-long programs depending on the topic of the group. Each client is responsible for their commitment to the group for the full program. Payment is due at the start of each module. All groups are to be paid whether or not the client attends as the spot in the group is saved for that particular client. A client may be asked to leave a group if more than 2 sessions are missed per module, as it will impact the group flow and bonding.

NOTE: While group therapy can be very helpful, it is not for everyone. Group therapy is available as space becomes open in groups and at the discretion of your provider.

I Agree to the No Show & Cancellation Process*	

Completed in secure client portal.

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AHCCCS ID #: 123456A

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Living and Balance Wellness Center

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602-314-6312 602-926-8317
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Financial Responsibility Agreement

Living and Balance Wellness Center allows the opportunity to pay for medical services using eligible medical insurance or cash pay. By using either method, the client/patient (you) understands that all remaining balances not paid by your health insurance or remaining balances accumulated using our cash pay program is solely the responsibility of yourself or parent/guardian (if a minor). You also agree to the following below based on applicability:

- Arizona Medicaid Recipients: Federal and State statutes require the utilization of all other sources of billing before utilizing Arizona Medicaid. Other sources include private, employer-provided health insurance and/or accident insurance coverage. In this case, Arizona Medicaid will be billed as the post primary insurance. You understand that Arizona Medicaid will only cover for services that are medically necessary to treat a medical condition or illness. You also understand that Arizona Medicaid will not cover any services in relation to employment.
- Medicare Recipients: You acknowledge that Living and Balance Wellness Center accepts Medicare assignment and You understand that You are responsible for a 20% co-pay of services rendered at Living and Balance Wellness Center. If you have a Medicare Advantage Supplement, it is the responsibility of the patient to verify that we take your insurance and understand that any balances not paid by your health insurance is the patient's responsibility.
- Private Insurance Recipients: You acknowledge that Living and Balance Wellness Center will bill your insurance for all medical services completed and it is the patient's responsibility to know and understand all covered health benefits per the patient's insurance policy. I understand that Living and Balance Wellness Center will verify patients' insurance for eligibility, but that does not guarantee that all services will be covered. You understand that if my health insurance does not cover any services received, You will be responsible for payment. You also acknowledge that any copay is due at time of service.
- Self Pay/Sliding Scale Fee Recipients: You acknowledge that the sliding scale fee program is a discount program to assist with the cost of medical services. You understand that all costs incurred by using the sliding scale fee program is your responsibility and balances must be paid for to continue services. You understand that assistance is available if eligible.
- Returned checks: You understand that Living and Balance Wellness Center will accept personal checks as payment, only if the checking account is under my name. You understand that any checks returned to Living and Balance Wellness Center unpaid by your bank will assess a charge to you for the amount of the check and a $20.00 return check fee.

Session Payments
Therapy sessions are paid via, check, credit card or debit card. Please fill out the credit card authorization form included in this packet and bring with you to your first session. This information is stored securely and is password protected. We charge clients on the day of their session.

Charges for unpaid services may be turned over to a collection agency which compromises confidentiality. We do not “carry over” session payments from week to week, or extend credit as this could constitute as an unethical “debtor/creditor” dual relationship and ultimately impact the therapeutic relationship.

Fee Increases
Fees are reviewed each year, and may increase periodically. Every consideration to a client’s current finances will be made. The increase will be discussed with the client, and a 30-day notice will be given prior to the increase.

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Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights
Arizona state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Arizona, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Arizona

What is surprise/balance billing, and when does it happen?
If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services
If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Non Emergency Services at an In-Network or Out-of-Network Healthcare Provider
The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://difi.az.gov/file-complaint-against-insurance-entity

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Arizona Division of Insurance at (602) 364-3100.

*This law does NOT apply to ALL Arizona health plans.

Please contact your health insurance plan at the number on your health insurance ID card or the Arizona Division of Insurance with questions.

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Grievance & Complaint Policy

Living and Balance Wellness Center LLC seeks to maintain and enhance our reputation of providing you with high-quality services. We value complaints as they assist us to improve our products, services and customer service. Living and Balance Wellness Center LLC is committed to being responsive to the needs and concerns of our clients or potential clients and to resolving your complaint as quickly as possible. This policy has been designed to provide guidance to both our clients and staff on the manner in which the client receives and manages your complaint. We are committed to being consistent, fair and impartial when handling your complaint.

The objective of this policy is to ensure:

- You are aware of our complaint lodgment and handling processes,
- Both you and our staff understand our complaints handling process,
- Your complaint is investigated impartially with a balanced view of all information or evidence,
- We take reasonable steps to actively protect your personal information,
- Your complaint is considered on its merits taking into account individual circumstances and needs.

Complaint Definition: Complaint is an expression of grief, pain, or dissatisfaction.

How to file a Complaint
If you are dissatisfied with a service provided by us, you should in the first instance consider speaking directly with the staff member/s you have been dealing with. If you are uncomfortable with this or consider the relevant staff member is unable to address your concerns you can lodge a complaint with us in one of the following ways:

- By telephoning us at 602-314-6312
- By writing to us at 10000 N 31st Ave Ste C218 Phoenix AZ 85051.
- By emailing us at info@livingandbalance.com
- In person by speaking to any of our staff or utilizing the anonymous grievance box.
- The Information you need to tell us:

When we are investigating your complaint, we will be relying on information provided by you and information we may already be holding. We may need to contact you to clarify details or request additional information where necessary. To help us investigate your complaint quickly and efficiently we will ask you for the following information:

- Your name and contact details, (optional)
- The name of the person involved, if any
- The nature of the complaint,
- Details of any steps you have already taken to resolve the complaint, if any
- Details of conversations you may have had with us that may be relevant to your complaint,
- Copies of any documentation that supports your complaint
- Suggestions you have for how we can help you resolve this issue

Living and Balance Wellness Center is committed to resolving your issues at the first point of contact; however, this will not be possible in all circumstances, in which case a more formal complaints process will be followed. We will acknowledge receipt of your complaint within three (3) business days. Once your complaint has been received, we will undertake an initial review of your complaint. There may be circumstances during the initial review or investigation of your complaint where we may need to clarify certain aspects of your complaint or request additional documentation from you. In such circumstances, we will explain the purpose of seeking clarification or additional documentation and provide you with feedback on the status of your complaint at that time. We are committed to resolving your complaint within 10 business days of you lodge your complaint, however, this may not always be possible on every occasion. Where we have been unable to resolve your complaint within 10 business days, we will inform you of the reason for the delay and specify a date when we will be in a position to finalize your complaint. During the initial review or investigation stage we may need to seek further clarification or documentation from you to assist us in resolving your complaint. If we have sought clarification or additional documentation from you and we are waiting on you to provide this information, we may not be able to meet our 10-business day finalization commitment. In such circumstances upon receipt of your clarification or additional documentation, we will indicate to you when we expect to be able to finalize your complaint.

Once we have finalized your complaint, we will advise you of our findings and any action we have taken. We will do this in writing unless it has been mutually agreed that we can provide it to you verbally. You have the right to make inquiries about the

current status of your complaint at any time by contacting us.

Our 6-point Complaint process

1. We acknowledge: Within three business days of receiving your complaint we will acknowledge receipt of your complaint.
2. We review: We undertake an initial review of your complaint and determine what if any additional information or documentation may be required to complete an investigation. We may need to contact you to clarify details or request additional information where necessary.
3. We investigate: Within 10 business days of receiving your complaint we will investigate your complaint objectively and impartially, by considering the information you have provided us, our actions about your dealings with us and any other information that may be available, that could assist us in investigating your complaint.
4. We respond: Following our investigation, we will notify you of our findings and any actions we may have taken in regard to your complaint.
5. We take action: Where appropriate we amend our business practices or policies.
6. We will record your complaint for continuous improvement process and monitoring through regular review, your persona] information will be recorded in accordance with relevant privacy legislation.

If a Complaint is made by Client about staff:
If you complain about a member of our staff, we will treat your complaint confidentially, impartially and equally (giving equal treatment to all people). We will investigate your complaint thoroughly by finding out the relevant facts, speaking with the relevant people and verifying explanations where possible.

We will also treat our staff members objectively by:

- Informing them of any complaint about their performance,
- Providing them with an opportunity to explain the circumstances,
- Providing them with appropriate support,
- Updating them on the complaint investigation and the result

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INFORMED TELEHEALTH & TELEMEDICINE CONSENT FORM

DEFINITION OF SERVICES:
I hereby consent to engage in telehealth/telemedicine with Living and Balance Wellness Center. Telehealth/telemedicine is a form of behavioral health and psychiatric service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I understand that telehealth/telemedicine involves the communication of my medical/mental health information, both orally and/or visually. Telehealth/telemedicine has the same purpose or intention as psychotherapy and psychiatric treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to telehealth/telemedicine:

CLIENT'S RIGHTS, RISKS, AND RESPONSIBILITIES:

- I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that protect the confidentiality of my medical information also apply to telehealth/telemedicine. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with Living and Balance Wellness Center.
- I understand that there are risks and consequences of participating in telehealth/telemedicine, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my behavioral health/ medical information could be accessed by unauthorized persons.
- There is a risk that services could be disrupted or distorted by unforeseen technical problems.
- In addition, I understand that telehealth/telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be asked to attend sessions at the agency.
- I understand that I may benefit from telehealth/telemedicine, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
- If I am experiencing a crisis, I can contact Arizona Crisis Services at 1(844) 534-4673 (text "HOME" to 741741). In an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.
- I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in Telehealth/telemedicine. I am responsible for providing the necessary computer, tablet or phone and internet access for my telehealth/telemedicine sessions, and for arranging a location with privacy that is free from distractions or intrusions for my session. It is the responsibility of the treatment provider to do the same on their end.
- I understand that dissemination of any personally identifiable images or information from the telehealth/telemedicine interaction to researchers or other entities shall not occur without my written consent.
- This will be reviewed annually.
- I consent to receive text messages or emails from Living and Balance Wellness Center (my "Provider") and their agents on my cell phone or other devices. I understand that emails sent by Provider may include appointment reminders or changes in previously scheduled appointments, or may provide advice or education and text messages may include appointment reminders or changes in previously scheduled appointments.
- Living and Balance Wellness Center does not charge for this service, but I understand that standard text messaging rates may apply as provided in my wireless plan. I have been advised that I may contact my carrier for pricing plans and details.
- I understand that I may revoke my request for further communications via text or email at any time by notifying my Provider in writing. However, if I continue to communicate with my Provider via text or email, my Provider can assume that my consent remains valid.
- Because emails sent over the Internet or texts sent over the control channel without encryption are not secure, I understand the risks associated with email and text messaging, including, without limitation, that emails and text messages could be intercepted by unknown third parties; email content can be changed without the knowledge of the sender or receiver; backup copies of email may still exist even after the sender and receiver have deleted the messages; and e-mail can contain harmful viruses and other programs.

- Living and Balance Wellness Center will not send, receive, or reply to text messages outside of text messages that are automated by our internal system that include appointment reminders or changes in previously scheduled appointments. Clients are encouraged to call or email a provider should they need to get in contact with their provider.
- My Provider has recommended that I delete all text messages or emails as soon as possible after reviewing them to limit any unauthorized exposure.

I HAVE READ, UNDERSTAND AND AGREE TO THE INFORMATION PROVIDED ABOVE REGARDING TELEHEALTH/TELEMEDICINE AT Living and Balance Wellness Center.

Completed in secure client portal.

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Living and Balance Wellness Center

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Use of Artificial Intelligence (AI) in Therapy Services Consent

As part of our commitment to providing high-quality care, we may use secure, HIPAA-compliant artificial intelligence (AI) tools to assist with certain aspects of service delivery. This may include, but is not limited to:

- Supporting documentation or note-taking
- Organizing treatment planning information
- Analyzing trends in client progress
- Enhancing communication (e.g., translation or transcription support)

Please note:

- AI tools do not replace your therapist or the clinical decision-making process.
- All AI tools used are secure, confidential, and compliant with applicable privacy laws (e.g., HIPAA).
- Your identifiable information will only be used with strict safeguards in place, or may be de-identified when possible.
- You have the right to ask questions and decline the use of AI-enhanced tools in your care.

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CONSENT TO USE THE TELEHEALTH BY Zoom or Google Meets

Telehealth by Zoom or Google Meets is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

- Telehealth by Zoom or Google Meets is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
- Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Zoom or Google Meets nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
- The Telehealth by Zoom or Google Meets Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
- I do not assume that my provider has access to any or all of the technical information in the Telehealth by Zoom or Google Meets Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by Zoom or Google Meets Service.
- To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

Electronic Notice
While we may try to return messages promptly, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine. Telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your provider chose to use information technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.
5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to services, better continuity of care, and reduction of lost work time and travelcosts. Effective services are often facilitated when the provider gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Providers may make assessments, diagnoses, and interventions based not only on direct verbal or auditory communications, written reports, and third-person consultations, but also on direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include but are not limited to the provider's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the Provider not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the Provider.

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Safety Agreements

Sobriety Policy
We ask that all clients, couples, families, and group members arrive to sessions sober and not under the influence of drugs and/or alcohol. If your provider notices that the client, or if services are conducted in the home- any present household member, at the time is intoxicated during and/or upon the arrival of the provider

for the session, the session will be immediately terminated. Should services be held at one of our offices we will also assist you in finding a safe ride home (via friend, family member or taxi) as driving while under the influence constitutes a risk to others and is a reportable offense. Once you are safely home, your provider will reschedule the session where this occurrence will be processed. Should the termination of the service be due to a present household member being the one under the influence your provider will reach back out to reschedule the session. You will be charged your full fee for the session if you arrive intoxicated.

Consent to a Safe Environment
Living and Balance Wellness Center, LBWC, takes the safety of all clients and staff seriously. It is the responsibility of the Guardian/Placement to provide a safe environment (if sessions are being performed in the client's home) for LBWC staff to provide services. LBWC recognizes and uplifts different cultural and demographic differences. The safety of the client and staff is a high priority. While LBWC Center staff are in the home servicing the clients, all animals (dogs, cats, etc) must be put away. This is for the safety of the LBWC staff, as well as eliminating distractions for the client. While LBWC is fully aware of the Arizona gun laws, firearms are not allowed out during time Living and Balance Wellness Center staff is in the home. If firearms are in the home, all firearms must be put away in a secure locked location. LBWC understands the child receiving the service will not be the only individual in the home, if there are additional person(s) in the home that could cause a distraction, we ask that a space be provided for the staff to conduct a successful session with the client is appreciated.

Failure to comply and the treatment team will be notified and services may be terminated.

By signing, I am fully aware of my responsibilities and expectations with the Consent to Safe Environment. If I am out of compliance with any of the above duties and responsibilities, I am fully aware that it is grounds for termination of services within Living and Balance Wellness Center.

Non-Discrimination Policy
The therapists at Living and Balance Wellness Center Counseling believe in supporting people of all ethnicities, cultures, orientations, and physical challenges. While our gender, ethnicity, orientation or spirituality may be different, we are open to discussing any concerns or questions you may have in working with a provider who is either a different race, religion, orientation or gender than you. Having an open discussion on any of these topics can lead to a greater level of trust and rapport. If you have any questions regarding our approach and style, or our non-discrimination policies, please feel free to discuss this with your provider now and/or in the future.

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Office Policies and Forms

Court Reports or Letters
We do not write legal letters or court reports on behalf of clients involving divorce, custody, or lawsuits. We do not write letters pertaining to legal matters to any outside person (i.e. doctor, school, attorney, etc.) or agency regarding your treatment. If you are referred for a substance abuse assessment, the summary of that assessment along with recommendations will be sent to the referring agency.

If a special circumstance arrives where a letter is required by court order, it will require your written consent and will be billed to you at $25.00 per page and in addition to our

hourly fee. We reserve the right to refuse to write letters on your behalf (unless court mandated) if we do not feel this would be in your best interest, if it places us in a dual relationship, or will compromise our therapeutic relationship. We will not write letters on your behalf if you are involved in a lawsuit for any aspect of your personal or professional life, as this places us in a dual relationship as both your provider and court advocate, thus crossing professional boundaries. If you are involved in a lawsuit, please understand that entering mental health into a court hearing may not always be in your best interest as it may compromise your confidentiality and your clinical files may be requested and your provider must speak honestly if under oath. Your provider will not be your advocate in a court hearing or speak on your behalf as that is not the nature of the provider/client relationship.

Court Fees
If you become involved in legal proceedings that require your provider's mandated participation, you will be expected to pay for all of your provider's professional time, including preparation and transportation time and costs, even if called to testify by another party. Because of the time involved and the interruption to their clinical work, you will be charged $250 per hour for time out of practice, time for preparation, travel time, and attendance at any legal proceeding on your behalf that you will be responsible for. Additionally, if other client sessions must be canceled, these must be covered at the rate of those sessions and will be billed to you. A provider is not a court advocate or friend. A provider must legally speak truthfully under oath.

Emotional Support Animals/ Service Dogs in Sessions
While we understand that Emotional Support Animals (ESA) often have therapeutic benefits we ask that if you are attending sessions with Living and Balance Wellness Center you must keep your ESA at home or put away should the session occur within your home. Under the American Disability Act (ADA) and Arizona law Emotional Support Animals are not identified as service animals.

Under the ADA, a service animal is a dog that's trained to perform disability-related tasks or work for the benefit of a person with a disability. In addition, Under AZ Law a service animal is defined as Under state law, a trained animal who is utilized to perform work or tasks for someone with a physical or sensory disability (like blindness) or an intellectual, psychiatric, or other mental disability. Living and Balance Wellness Center welcomes all Service Animals.

Provider Time off Policy
Should your provider have scheduled or unforeseen time away this will be communicated with as much advance notice as possible. During your provider's scheduled out of office time, he/she will not be available for communication via phone, or email. If you are a threat to yourself or another during that time, please call 911 immediately.

Holiday, Weekend and Evening Contact
If you have questions or need to schedule or cancel please call the front office directly. If you need to cancel please do so within 48 hours of the appointment date as this helps the therapist, should there be a need to schedule another client temporarily in that time spot.

Your provider will make every effort to return a call, email or text message within 24 business hours during a scheduled work week. If a call or email arrives during a holiday, office closure, weekend or evening, your provider will make efforts to respond during the first working day following. If you are facing a life threatening emergency, call 911 immediately.

Explanation of Dual Relationships
While a provider and client relationship can feel psychologically close, it is one that is professional in nature with important boundaries. It is unethical for a provider to invite you into a business venture, ask you for personal favors, start a social relationship with you, etc. These examples are called "dual relationships" and can negatively impact clinical/professional boundaries. Although your sessions may be intimate psychologically, it is important to acknowledge that it is a strictly

professional relationship. On the rare occasion that your provider sees a client outside of the office (when they may accidentally run into each other in public), your provider will be highly discreet and will maintain your confidentiality. He or she will do their best to follow your lead, and thus it is your choice to acknowledge the encounter and your therapist. If you do not choose to acknowledge the encounter, your therapist will respect this and will follow your lead.

Should your Provider engage in a Dual Relationship or Sexual contact with you as a client or guardian of a client please report this immediately to our Marie Davis, CEO of Living and Balance Wellness Center, LLC at 602-403-5160 or a supervisor with any concerns so that we can resolve, and if necessary report, any findings as soon as possible, as serving you is our highest priority.

Policy Regarding Internet, Professional, and/or Social Networking Sites
On the topic of Social Media and Internet Sites, our primary concern is your privacy.

If you follow the Living and Balance Wellness Center business page on a site like Instagram for example, please note that your Living and Balance Wellness Center providers will not follow you back. If there are things from your online life that you wish to share with your provider, please bring them into your sessions where they can be viewed and explore together, during the session.

Please do not use messaging on Social Networking sites such as Twitter, Facebook, Instagram, or LinkedIn to contact Living and Balance Wellness Center providers. These sites are not secure and messages may not be read in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with Living and Balance Wellness Center providers publicly online if there is an already established client/provider relationship. Engaging this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact your provider between sessions, please do so directly via email or phone.

“Friending”
It is the Living and Balance Wellness Center policy to not accept friend or contact requests from current or former clients on any social networking site. We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our professional relationship. If you have questions about this, please bring them up when you meet with your provider to discuss further.

Physical Contact
Sexual contact is never acceptable in professional relationships. Romantic or sexual talk, flirting, or sexual innuendos and sexual jokes are also unacceptable in the professional relationship. If you should express a sexual comment or joke while in session directed to your provider, we will explore this comment professionally and in a non- shaming way within a professional non-sexual relationship.

Referrals of Friends, Family, Co-workers
The greatest compliment a provider can receive are referrals from current or former clients. There are times when clients wish to introduce their provider so they can make a recommendation as a referral, which is ethical and acceptable. Please understand that your confidentiality is extremely important to Living and Balance Wellness Center. We will not acknowledge you as a client to other clients or anyone outside of Living and Balance Wellness Center without your written consent, or unless mandated by a court of law.

On occasion a client may say, “My friend Jane/John Doe mentioned that she/he started seeing you and is enjoying the work you are doing with him/her.” This is an example of our standard response: “I appreciate any referrals clients make, however, I cannot reveal who I see in therapy, and thus I cannot remark on who I see clinically at this time.” Because this may sound rather official to clients, and because Living and Balance Wellness Center will not acknowledge who is seen in services, including you, we thank our clients here on this page one time in advance for any referrals they may make: Thank you for the referral; We are honored by your trust and confidence

Completed in secure client portal.

Client Full Name: Jane Q Doe, Jr.
AHCCCS ID #: 123456A

Client Full Name: Jane Q Doe, Jr.
AHCCCS ID #: 123456A

Living and Balance Wellness Center

10000 N 31st Ave, Phoenix, AZ 85051-9620
602-314-6312 602-926-8317
www.livingandbalance.com

Transportation Consent

You must give your written permission and consent to be transported by Living and Balance Wellness Center Staff. I give my permission to be transported in a motor vehicle driven by Living and Balance Wellness Center Staff Members. I understand that I may be transported by Living and Balance Wellness Center staff to and from places such as but not limited to school, home, special events, activities, or other events as necessary and as related to my services. I understand that inherent risks are involved in traffic delays, accidents, etc. I acknowledge and accept the risk concerning being transported by those above. I further acknowledge that I am expected to follow all applicable laws regarding riding in a motor vehicle and is expected to follow the directions provided by the Living and Balance Wellness Center Staff Member.

I have read, understood, that:

1. I will be traveling in a motor vehicle driven by an adult and I am to wear my safety belt while traveling;
2. We are expected to respect each other, the vehicles I ride in, and the people I travel with during the trip;
3. Riding in a motor vehicle may result in personal injuries or death from wrecks, collisions or acts by riders, other drivers, or objects; and
4. I am to remain in my seats and not be disruptive to the driver of the vehicle.

I recognize that by participating in this activity, as with any activity involving motor vehicle transportation,I may risk personal injury or permanent loss. I hereby attest and verify that I have been advised of the potential risks, that I have full knowledge of the risks involved in this activity, and that I assume any expenses that may be incurred in the event of an accident, illness, or other incapacity, regardless of whether I have authorized such expenses. As a condition for the transportation received, I, for myself, my executors, and assigns, further agree to release and forever discharge Living and Balance Wellness Center and their agents, officers, employees, and volunteers from any claim that I might have myself or that I could bring on my minor's behalf concerning any damages, demands or actions whatsoever, including those based on negligence, in any manner arising out of this transportation. I have read this entire waiver and permission form, fully understand it, and agree to be legally bound by its terms. I agree and understand that if I wish to revoke this consent I will do so in writing and deliver such revocation to Living and Balance Wellness Center. I understand that Living and Balance Wellness Center also has the right to refuse to transport my minor for any reason.

Confirmation of Understanding to Receive Services
By signing this form, I certify:
That I have read or had this form read and/or had this form explained to me.
That I fully understand its contents including the risks and benefits of services.
That I have been given ample opportunity to ask questions and any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Completed in secure client portal.

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Attestation: Right to Choose

At Living and Balance Wellness Center, we value your right to make informed decisions about your care. You have the right to choose the provider that best meets your needs. As part of our commitment to ensuring you receive the most appropriate services, we want to inform you that you are not required to receive services solely from Living and Balance Wellness Center.

You have the Right to Choose in your care, and you are encouraged to explore all available options for behavioral health and wellness services in Arizona. If you wish to seek services elsewhere or explore additional providers, below are alternative organizations that offer similar services:

1. **Community Bridges, Inc. (CBI)**
   Website: www.communitybridgesaz.org
   Phone: 877-931-9142
2. **211 Arizona (Information & Referral Services)**
   Website: www.211arizona.org
   Phone: 211 (Call for local resources and provider referrals)
3. **Solari Crisis & Human Services**
   Website: www.solariservices.org
   Phone: 844-534-4673

If you decide to transition to another provider, our team is available to assist you in transferring records and coordinating care as needed. Your well-being is our top priority, and we support your right to receive care that aligns with your personal needs and preferences.

Please sign below to acknowledge that you have received this notice of provider choice.

Client Acknowledgment

I acknowledge that I have received this notice informing me of my right to choose a provider other than Living and Balance Wellness Center and that I may seek services from alternative providers in Arizona. I understand that I may request assistance in transitioning to another provider if needed.

If you have any questions or need further assistance, please do not hesitate to contact our office at Living and Balance Wellness Center Phone: 602-314-6312 Fax: 602-926-8317 email: info@livingandbalance.com

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Acknowledgement, Authorization and Waiver

- I authorize Living and Balance Wellness Center to perform the treatment or necessary procedure to me/ or to my (for Parent/Guardian) dependent.
- I confirm that I read the patient rights, disclosures, privacy practices, notice of health information, consent for treatment, financial agreement, consent and I agree with them.
- I understand that I can decline treatment at anytime.
- I understand that consent to treatment is ongoing and can be updated by either party.
- I acknowledge that all information I provided in this form is true and accurate.
- I accept and agree to the above 5 bullet points of the acknowledgement, authorization and waiver agreements*

Completed in secure client portal.

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Items Needed to Finalize Your Enrollment

Adults (18 and above): provide drivers license or state ID (passports permitted), insurance card(s) front and back of each card. If you are using EAP insurance and have the authorization letter please include this letter. If you do not have the authorization letter we can request from the plan listed.

Minors (17 and under): One guardian drivers license or state ID (passports permitted), insurance card(s) front and back of each card. Birth Certificate of child or guardianship paperwork. We require one of these forms of identification to ensure the minor is accompanied by a legal guardian. If you are using EAP insurance and have the authorization letter please include this letter. If you do not have the authorization letter we can request from the plan listed. If you have any pertinent guardianship paperwork please include this.

Adult Dependent: Adult client and One guardian drivers license or state ID (passports permitted), insurance card(s) front and back of each card. If you are using EAP insurance and have the authorization letter please include this letter. If you do not have the authorization letter we can request from the plan listed. If you have any pertinent guardianship paperwork please include this:

- Upload drivers license/state ID
- Insurance Card(s) or EAP letter Front
- Insurance Card(s) Back or EAP letter
- Birth Certificate for a Minor
- Court documents for dependent (when applicable)
- Any additional documents you want our office to place in your chart

Signatures and Consent
By signing below you consent to the treatment of yourself or your dependent who you are authorized to sign for treatment to occur. You confirm by signing as a guardian (if applicable) you are lawfully authorized to sign for the minor or adult and act as their guardian.

Completed in secure client portal.

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Document Acknowledgement

I, Jane Q Doe, Jr., acknowledge that I have received, read, and understood the following documents:

1. How to Contact Supervisors
2. No Show & Cancellation Policy
3. Financial Responsibility Agreement
4. Surprise/Balance Billing Disclosure Form
5. Grievance & Complaint Policy
6. Telehealth Consent
7. AI Consent
8. Telehealth Service Consent
9. Safety Agreements
10. Office Policies and Forms
11. Transportation Consent
12. Attestation: Right to Choose
13. Acknowledgment, Authorization and Waiver
14. Items Needed to Finalize Your Enrollment

By signing below you consent to the treatment of yourself or your dependent who you are authorized to sign for treatment to occur. You confirm by signing as a guardian (if applicable) you are lawfully authorized to sign for the minor or adult and act as their guardian.

Client Name: Jane Q Doe, Jr.

Client Signature: Date:

Completed in secure client portal.

Client Full Name: Jane Q Doe, Jr.

AHCCCS ID #: 123456A