Patient Handbook

A SYSTEM OF CARE AND RECOVERY

reMIND HEALTH GROUP, LLC | 1939 GOLDSMITH LANE, SUITE 117, LOUISVILLE, KY 40218

WELCOME

ReMIND – (Remember, Recollect, Recall, Reminisce)

All those words are why we exist. Our experienced team of caring professionals are here to guide, support and encourage you to "bring an image or idea from the past into the mind."

During your journey we want to help you recover a time that was lost – a time where you maintained control of your life. We are here to help you regain that control and return to a productive and meaningful way of life. Addiction is a chronic dysfunction of the brain system that involves reward, motivation, and memory. Over time, addictions can seriously interfere with your daily life. That's why it's important for anyone who is experiencing addiction to seek help.

Addiction is complex – but; it's treatable. re◦MIND is committed to addressing the unique needs of each patient. We believe addiction is a multi-faceted disease with three unique levels: mind (psychological), body (biological), and spirit (emotional/social). Therefore, our treatment planning will focus on these areas and are designed to bring balance to shattered lives and families to ensure the best possible outcomes for each patient. Recovery is possible!
As addiction is multi-faceted, treatment is also multi-faceted. That means, our treatment specialists design programs and treatment that will support the patient and the family. Offering both education, treatment, case management, and crisis intervention for those struggling with the disease of addiction and recovery.

Please let us know if we can assist you in your journey of recovery. We want to build a relationship of success and re◦MIND you of a life without addiction.
Sincerely,

Jeff A. Beaty, DHEd, LMSW, MSHA
Chief Administrative Officer

What We Do

re◦MIND is dedicated to serving those who struggle with behavioral and mental health needs and those struggling with the disease of addiction. As a leader in the community, we strive to demonstrate and document the healthcare needs and barriers to care of our community and link our services to them. We currently provide health services to adults and families who are experiencing mental health or substance use problems.

Our Mission

We promote the prevention of and recovery from addiction and mental illness among patients, families, and communities by providing effective leadership and delivering best-in-class, culturally competent services.

Our Core Values

- **Teamwork**: Work together effectively to achieve our goals, while encouraging individual contributions and responsibility.
- **Integrity**: Communicate openly and honestly and build relationship based on trust, respect, and compassion.
- **Excellence**: Improve our performance continuously and strive for excellence.
- **Service**: Satisfy our patients and referral sources every time through comprehensive integrated services.
- **Community**: promote health and wellness throughout the communities we serve.

ACKNOWLEDGMENT OF PATIENT EDUCATION AND MATERIALS

I acknowledge I have received education and/or materials on the following items and have been afforded the opportunity to ask any questions or seek clarification.

- Patient rights and grievance procedures
- Notice of Privacy Practices and 42 CFR Rules on Confidentiality
- ReMIND's facility/program guidelines and rules/regulations
- Fee Schedule and billing procedures
- Treatment options, including withdrawal management
- Benefits and risks associated with each treatment option
- Addiction treatment and pregnancy
- Prevention and treatment of chronic viral diseases including HIV, Hepatitis, Tuberculosis, and sexually transmitted infections
- The risk of exposure to chronic viral diseases including HIV, Hepatitis, Tuberculosis, and sexually transmitted infections
- Expected therapeutic benefits and adverse effects of treatment medication
- Risk for overdose, including drug interactions
- Overdose prevention and reversal agents
- The disease of addiction
- Information regarding the patient's diagnosis
- The effects of alcohol and other drug abuse
- Family issues related to substance use disorder
- Relapse prevention
- Noncompliance and discharge procedures
- Potential drug interactions
- Lab Testing procedures
- Medication Adherence Policy
- Consent for Alcohol and Drug Assessment and Treatment

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (NPP)

Effective Date: 01/31/2021

Privacy Policy

re◦MIND is committed to providing you with quality behavioral healthcare services. An important part of that commitment is protecting your health information according to current applicable laws. This notice ("Notice of Privacy Practices") describes your rights and our duties under Federal Law. Individually identifiable information about your past, present, or future health or condition, the provision of health care to you or payment for health care is considered "Protected Health Information" (PHI).

Our Commitment

We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when, and why we may disclose your PHI. Except in a specific circumstance, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure. We are required to follow the privacy practices described in this Notice though we reserve the right to change our privacy practices and the terms of this Notice at any time.

Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. Notification of revisions of this Notice of Privacy Practices will be provided as follows upon request, electronically, or as posted in our place of business.

42 CFR Part 2 "Confidentiality" Summary

Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records (Part 2) addresses concerns about the potential use of Substance Use Disorder (SUD) information in non-treatment-based settings such as administrative or criminal hearings related to the patient. Part 2 is intended to ensure that a patient receiving treatment for a SUD in a Part 2 Program does not face adverse consequences in relation to issues such as criminal proceedings and domestic proceedings such as those related to child custody, divorce, or employment. Part 2 protects the confidentiality of SUD patient records by restricting the circumstances under which Part 2 Programs or other lawful holders1 can disclose such records.

Part 2 Programs are federally assisted programs. In general, Part 2 Programs are prohibited from disclosing any information that would identify a person as having or having had a SUD unless that person provides written consent. Part 2 specifies a set of requirements for consent forms, including but not limited to the name of the patient, the names of individuals/entities that are permitted to disclose or receive patient identifying information, the amount and kind of the information being disclosed, and the purpose of the disclosure (see §2.31).4 In addition to Part 2, other privacy laws such as the Health Insurance Portability and Accountability Act of 1996

(HIPAA) have been enacted. HIPAA generally permits the disclosure of protected health information for certain purposes without patient authorization, including treatment, payment, or health care operations.

Violations of the federal law and regulations by treatment facilities is a crime. Suspected violations may be reported to the U.S. Attorney General and to the Substance Abuse and Mental Health Services (SAMHSA) office responsible for oversight of the treatment facility.

Use and Disclosure of Your PHI

We use and disclose Protected Health information for a variety of reasons. We have a limited right to use and / or disclose your PHI for purposes of treatment, payment, and for our healthcare operations. For uses beyond that, we must have your written authorization unless the law permits or requires us to make the use or disclosure without your authorization. If we disclose your PHI to an outside entity for that entity to perform a function on our behalf, we must have in place an agreement from the outside entity that will extend the same degree of privacy protection to your information that we must apply to your PHI. However, the law provides that we are permitted to make some uses or disclosures without your consent or authorization. The following describes and offers examples of our potential uses or disclosures of your PHI.

Generally, we may use or disclose your PHI as follows:

For Treatment: We may disclose your PHI to doctors, nurses, and other healthcare personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team, or with central pharmacy staff. Your PHI may also be shared with outside entities performing ancillary services relating to your treatment, such as lab work, for consultation purposes, or licensure boards, accreditation agencies, and / or community mental health agencies involved in the provision or coordination of your care.

To Obtain Payment: We may use or disclose your PHI to bill and collect payment for your healthcare services. For example, we may contact your employer to verify your employment status, and / or release portions of your PHI to the Medicaid program, collection agencies, and / or a private insurer to get paid for services that we delivered to you. We may release information to the Office of the Attorney General for collection purposes.

For Health Care Operations: We may use / disclose your PHI in the course of operating our agency. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes. Since we are an integrated system, we may disclose your PHI to designated staff in our other facilities having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse. Release of your PHI to other state agencies might also be necessary to determine your eligibility for publicly funded services.

Health and Human Services: We are required to disclose PHI to the Department of Health and Human Services should they be investigating or determining our compliance with the HIPAA Privacy Rules.

Qualified Business Associates: We may disclose you PHI to Business Associates that are contracted by us to perform services on our behalf which may involve receipt, use or disclosure of your PHI. All our Business Associates (BA) must agree to:

1. Protect the privacy of your PHI
2. Use and disclose the information only for the purposes for which the Business Associate was engaged
3. Be bound by 42 CFR Part 2
4. If necessary, resist in judicial proceedings any efforts to obtain access to patient records except as permitted by law.

Police Investigations: We may disclose your PHI to law enforcement under the following conditions:

1. When the PHI is directly related to the commission of a crime on the premises or against our personnel or to a threat to commit such a crime.
2. We may disclose information required to report under state law incidents of suspected child or adult abuse and neglect to the appropriate state or local authorities. However, we may not disclose the original patient records, including for civil or criminal proceedings which may arise out of the report of suspected child or adult abuse and neglect, without consent.

Emergency Situations: We may disclose information to medical personnel for the purpose of treating you in an emergency.

Central Registry: By enrolling in Medication Assisted Treatment at this facility, your health information may be released to the Central Registry within the Commonwealth of Kentucky. This information will be viewed by staff and any legally licensed Medication Assisted Treatment facility in the United States when you present and request enrollment and/or emergency medication services. In addition, the above-described information could be released to any duly authorized or appointed State Opioid Treatment Authority and their staff for the purposes of monitoring dual enrollment verifications.

Authorizations to Use or Disclose Your PHI

For uses and disclosures beyond treatment, payment and operations purposes we are required to have your written authorization unless the use or disclosure falls within one of the exceptions described below. As an example, most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your written authorization.

Special privacy protections also apply to HIV-related information, alcohol and substance abuse treatment information, and mental health information. This means that parts of this Notice may not apply to these types of information because stricter privacy requirements may apply. Signature Health will only disclose this information as permitted by applicable state and federal

laws. If your treatment involves this information, you may contact our Privacy Officer to ask about the special protections.

Authorizations to use or disclose PHI can be revoked at any time to stop future uses or disclosures. We are unable to take back any uses or disclosures of your PHI we have already made with your authorization.

Uses & Disclosures of PHI Not Requiring Consent or Authorization

The law provides that we may use / disclose your PHI without consent or authorization in the following circumstances:

When Required by Law: We may disclose PHI when a law requires that we report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

For Public Health Activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.

For Health Oversight Activities: We may disclose PHI to our central office, the protection and advocacy agency, or other agency responsible for monitoring the healthcare system for such purposes as reporting or investigation of unusual incidents and monitoring of the Medicaid program.

To Avert Threat to Health or Safety: To avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm to your health and safety or to the health and safety of the public or of another person.

For Specific Government Functions: We may disclose PHI to Government benefit programs relating to eligibility and enrollment, and for national security reasons.

For Research, Audit or Evaluation Purposes: In certain circumstances, we may disclose PHI for research, audit, or evaluation purposes.

For Deceased Individuals: We may discuss PHI relating to an individual's death if state or federal law requires information for collection of vital statistics or inquiry into cause of death or to coroners, medical examiners, or funeral directors so they may do their jobs.

For Law Enforcement Purposes: We may disclose PHI to law enforcement officials. For example, we may make these types of disclosures in response to a valid court order, subpoena, or search warrant; to identify or locate a suspect, fugitive, or missing person; or to report a crime committed on our premises.

Your Rights Regarding PHI

You have the following rights relating to your Protected Health Information:

To Request Restrictions on Uses / Disclosures: You have the right to ask that we limit how we use or disclose your PHI. We will consider your request but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use or disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses or disclosures that are required by law.

To Choose How We Contact You: You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request if it is reasonably easy for us to do so.

To Inspect and Request a Copy of Your PHI: Unless your access to your records is restricted for clear and documented reasons, you have the right to see your protected health information upon your written request. You may not see or get a copy of information gathered or prepared for a legal proceeding or if your requests cover psychotherapy notes. We will respond to your written request within 30 days. If we deny your access, we will give you written reasons for the denial and explain how to request a determination review. If you want copies of your PHI, a charge for copying may be imposed, depending on the circumstances. You have the right to choose what portions of your information you want copied and to have prior information on the cost of copying.

To Request Amendment of Your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request in writing that we correct or add to the record. Your request should be submitted to our Privacy Officer. We will respond within 60 days of receiving your request. If we accept your request, we will tell you and will amend your records by supplementing the information in the records. We will also tell others that need to know about the change in PHI. We may deny the request. Any denial will state our reasons for the denial and explain your rights to have the request and denial, along with any statement in response to the denial that you provide, appended to your PHI.

To Find Out What Disclosures Have Been Made: You have a right to get a list of when, to whom, for what purposes, and what content of your PHI has been released other than instances of disclosure for treatment, payment, and operations; to you, your family, or the facility directory; or pursuant to your written authorization. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 2003. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests. We will notify you of any such costs prior to efforts to comply with your request.

Right to Voice Concerns: You have the right to file a complaint in writing to us or with the U.S. Department of Health and Human Services if you believe we have violated your privacy rights. Any complaints to us should be made in writing to our Privacy Officer at the address listed below. We will not retaliate against you for filing a complaint.

re◦MIND:
Attn: Privacy Officer
123 Anywhere Street
Placeholder, KY 40291
(502) 555-1212

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with person listed below. You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Toll Free: (800) 368-1019
TDD Toll Free: (800) 537-7697

We will take no retaliatory action against you if you make such complaints.

Patient Signed Consent

I fully understand and agree to these policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient Name: _____
Last First Middle Initial

Patient/Parent/Guardian Signature: _____

Printed Name: _____ Date _____

PATIENT RIGHTS AND RESPONSIBILITIES STATEMENT

AS A ReMIND PATIENT, YOU HAVE THE RIGHT TO:

ACCESS SERVICES in a safe and respectful manner

- Receive services at ReMIND regardless of your race, color, religion, sex, marital status, sexual orientation, gender identity or expression, English language proficiency, national origin, age, disability, veteran status, or any other status protected by law.
- Receive respect and consideration from every employee, volunteer, or trainee you interact with at ReMIND.
- Feel safe from harm and free from verbal, physical, or psychological abuse, intimidation, or harassment when you are at ReMIND's facilities.

PRIVACY regarding your personal health information

- Expect ReMIND to comply with the Federal and State privacy laws when using or disclosing information about you or the health care and related services you receive at ReMIND.
- Receive a copy of ReMIND's Notice of Privacy Practices (NPP) when you register as a new patient so that you will be more fully informed about your privacy rights.
- Active involvement in your ongoing care.
- Help ReMIND providers and staff to develop a plan for the treatment and services you receive at ReMIND.
- Provide (or withhold) your consent to voluntary treatment, including your participation in clinical research, and be informed about the consequences of refusing any treatment or service.
- Provide ReMIND staff members with positive or negative feedback about your care or voice your concerns, or grievances about the health center.

TIMELY INFORMATION about your care

- Receive complete information about your diagnosis, and treatment or service plan in plain language that you can understand.
- Obtain a copy of your medical records upon request unless the law permits ReMIND to withhold them.
- Receive an explanation of the costs associated with your care at ReMIND.
- Obtain assistance with referrals to other providers.

QUALITY SERVICES from our health center

- Received coordinated health care treatment and services consistent with professional standards.
- Receive services from licensed and credentialed ReMIND providers.
- Request ReMIND to provide hearing, language, literacy or other communication assistance required by law.
- Receive services and care in the least restrictive environment feasible, free from chemical or physical restraints.

AS A ReMIND PATIENT, YOU ARE RESPONSIBLE FOR:

YOUR PERSONAL INTERACTIONS with our health team

- Treat ReMIND employees, volunteers, trainees, contractors, other patients, and guests with respect at all times.
- Do not make any threatening or offensive statements at ReMIND's facilities.
- Do not engage in any act of physical violence or other threatening or inappropriate behavior at ReMIND's facilities.
- Do not distribute or use alcohol or other drugs on ReMIND's property or enter a ReMIND facility or program under the influence of illegal drugs or alcohol.

ACTIVE ENGAGEMENT in your care

- Take an active part in your treatment or service plan at ReMIND and stay in contact with your providers about your care.
- Request any hearing, language, literacy or other communications assistance you may need at least 48 hours prior to your visit.
- Show up for your appointments at least 15 minutes ahead of schedule and provide advance notice whenever it becomes necessary to cancel an appointment at ReMIND.
- Contribute to the cost of your care that the law or the health plan that you participate in requires you to pay.

TIMELY INFORMATION sharing

- Provide ReMIND with complete, accurate, and truthful information at all times.

ReMIND's Patient Rights and Responsibilities Policy grants ReMIND discretion to take action placing limits on a patient's ability to receive treatment or services at ReMIND based on a patient's failure to meet their Responsibilities or for any other reason permitted by law. Likewise, any ReMIND patient has the discretion to decide not to seek further treatment or services at ReMIND based on ReMIND's failure to abide by the patient Rights set forth in this Statement or for any other reason.

PATIENT SIGNATURE:

_____

PATIENT PRINTED NAME:

_____

DATE: _____

GRIEVANCE PROCEDURES

It is the policy of re◦MIND to ensure that every patient has the right to follow the grievance procedure without reprisal. Patients with questions about their treatment or those who feel they are being treated unfairly are encouraged to discuss their concerns with their counselor, the counselor's supervisor or the facility's Administrative Officer.

Each patient has the right to file a written grievance with re◦MIND. The form to file the grievance may be obtained from the patient's counselor or Administrative Officer. Your counselor or the Administrative Officer is available to assist you with the form if you need their help.

The form includes:

1. The name of the patient
2. The name of the patient's counselor
3. The name of the program the patient is in
4. The date and time of the incident
5. The persons involved (or physical description)
6. Incident or description being grieved
7. Patient's signature
8. Date of grievance
9. Title and address of arbitrator of the grievance

Should the patient need assistance in filing a grievance, the patient's counselor or the Administrative Officer will be available to help the patient with this procedure. Upon receipt of a grievance, the patient filing the grievance shall be notified of its receipt in writing within ten business days.

The sequence of activities which will occur as a part of the grievance process are as follows:

1. Patient or authorized designees presents complaint to the Administrative Officer or any other staff member.
2. The Administrative Officer or designee will initiate contact with the grievant within ten working days of receipt of complaint in writing.
3. Administrative Officer will investigate the complaint and attempt to resolve the grievance within 10 days from the date of the filing of the grievance.
4. If the Administrative Officer or designee is unable to resolve the complaint, an agency grievance committee will be formed, hear the facts, and issue a written statement to the patient and other concerned parties within the 21 days. If the patient is not satisfied, he / she may appeal to an impartial decision-maker outside the agency. The Administrative Officer will assist the patient with the appeal.

The patient will be provided a copy of all activity regarding the grievance including:

1. The copy of the grievance
2. The documentation of the resolution of the grievance, and
3. The copy of the letter to the patient reflecting the resolution of the grievance will be kept by the Administrative Officer for two full calendar years following the resolution.

Ombudsman

Cabinet for Health and Family Services
Office of the Ombudsman
275 E. Main Street, 2E-O
Frankfort, KY 40621

Phone: 502-564-5497

Fax: 502-564-9523

Email: CHFS.Listens@ky.gov

Website: https://chfs.ky.gov/agencies/os/omb/Pages/default.aspx

Appeal

If the patient is not satisfied with the outcome or decision of their grievance, the patient has the right to file an appeal. Patient may make a written request to file an appeal within thirty (30) days of the receipt of the notification.

The procedure for filing an appeal is as follows:

1. The patient shall make a written request to appeal the initial grievance to the Administrative Officer with thirty (30) days of receipt of the notification.
2. The appeal must be date and signed by the patient, or other individual assisting the patient in filing the grievance. The appeal should include the basis for the appeal, any supporting information, and the patient's reason for appealing the initial decision.
3. Patients shall be informed of the right to obtain outside advice from legal counsel at their own expense or file a grievance with any outside organization as listed below in this procedure.
4. A written acknowledgement of receipt of the appeal shall be provided to the patient filing an appeal by the Administrative Officer, or designee, receiving the appeal. The written acknowledgement shall be provided to the patient within seven (7) working days of receipt of the appeal and shall include:
    - Date appeal was received
    - Summary of the appeal
    - Overview of appeal investigation process
    - Timetable for completion of appeal and notification of resolution
    - Treatment provider contact name, address, and telephone number
5. The Administrative Officer shall make a resolution decision on the appeal within twenty-one (21) calendar days of receipt of the grievance.

6. Patient notification of resolution plan shall be made by the Administrative Officer taking the initial formal grievance.

Any patient who files a written grievance will be protected from any interference, coercion, discrimination, or reprisal.

Outside Grievance Bodies

Patient shall be informed of outside organizations in which they may file a grievance, including but not limited to the following:

1. The Kentucky Cabinet of Health and Human Services (CHFS), Office of the Ombudsman as listed previously.

2. The Kentucky Cabinet of Health and Human Services (CHFS), EEO / Civil Rights Branch, 275 E. Main Street, 5C-D, Frankfort, KY 40621, (502) 564-7770.

3. The U.S. Department of Health and Human Services, 200 Independence Avenue, Washington, D.C. 20201, (877) 696-6775.

Patient Signature: _____ Date:_____

CONSENT FOR ALCOHOL AND DRUG ASSESSMENT AND TREATMENT

I understand that as a patient of re◦MIND, LLC ("re◦MIND) I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment which will be explained to me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over a course of several months.

- **Participant Responsibilities in all Programs**.
  For re◦MIND to provide the best possible service you must agree to:
  - Actively and earnestly participate in developing your treatment plan and follow that plan.
  - Follow rules established by the program and staff.
  - Maintain behavior / conduct that assures the safety, comfort, and well-being of all persons.
  - Participate in all program services including compliance with medical protocol, group education programs, counseling services, self-help meetings, and recreational and social activities.
  - Pay for services, if applicable, which may be based on a sliding fee schedule in accordance with your agreement with re◦MIND as determined during your intake appointment or financial assessment.

- **Assessment Process and Treatment Planning**.
  Everyone entering our program will participate in an assessment process to determine the nature and the extent of the problems you are facing. Your assessment may include a nursing physical screen, a physical examination, lab tests, and a brief biopsychosocial assessment to help us better understand how we might be of assistance. Your honest answers will help us see how you view the situation and will assist us in working together with you to develop a plan that truly addresses your needs and goals. At any point if something is not clear to you, please ask about it. This process helps the clinician and the person served identify the individual's strengths, needs, abilities, and preference for recovery so that an individual treatment plan may be developed.

  re◦MIND provides Person-Centered planning for our participants. When developing an individual's Plan, re◦MIND seeks to include family and professional collaboration during planning, goal setting, and throughout service delivery. Regular opportunities for individuals to discuss progress towards their goals and provide feedback on their program is an important part of our treatment services.

  Person-centered planning involves the development of a "toolbox" of methods and resources that enable people to be involved in the planning process, and to take ownership of their own paths to success. Professionals providing services help them figure out where they are, where they want to go and how best to get there. re◦MIND also encourages peer-

to-peer support and networking among persons served. Our goal is for you to meet your goals!

- **Course of Treatment Services and Activities**.
  During your stay with us, you will be engaging in a variety of services and activities that may include but not be limited to the following:

  - **Outpatient Assessment** – A bio-psychosocial history including behavioral health or substance use history, laboratory testing, and other relevant measures.
  - **Treatment Plan development** – a course of action recommended by the clinical team with your input to achieve your treatment goals. Activities and target dates will help you on your way.
  - **Individual and/or group counseling** – most of our programs include both settings, but your treatment program will be individualized to your needs, abilities, and preferences.
  - **Medication treatment** - The use of authorized drugs to treat your dependence on alcohol or other drugs. For treatment in the MAT (Medication Assisted Treatment) Program, I understand that the physician or other licensed provider may prescribe various medications to patients in recovery. The medications are used in conjunction with individual and group counseling. Further, any medication I receive may have an adverse reaction and/or possible side effects. Medications that may be administered include but are not limited to Buprenorphine/Naloxone. The goal of MAT treatment is to stabilize functioning. I understand that buprenorphine or other MAT medications may interact with other prescription medications, vitamins, and nutritional supplements. Therefore, I agree to inform the physician or other licensed providers of all medications, vitamins, and supplements that I take.
  - **Clinical services** – The use of supportive counseling, educational groups, self-help meetings, discharge planning and case management.
  - **Drug Screens** – re◦MIND utilizes urinalysis drug screens and quick-response breathalyzer tests in our treatment programs.
  - **Medical services** - Including a medical history, nursing assessment, physical examination, laboratory tests, and tests for contagious diseases, and other related diagnostic tests.
  - **Psychiatric Evaluation** – A Psychiatrist or other licensed provider will perform an evaluation to help determine any mental health or psychiatric diagnoses and any recommended treatment, including therapy and/or medication administration.
  - **Psychiatric Medication Management** – A Psychiatrist or other licensed provider will monitor a Medication Management program, where the person served will meet and discuss with the Psychiatrist or other licensed provider the effects and outcomes of any prescribed medications.

  I understand that while psychotherapy and/or medication may provide benefits, it may also pose some risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. I realize that sometimes medications may have unwanted side effects. We ask that you participate fully in each activity as it will enhance its meaning to you as an individual. Our goal is ultimately to help you achieve goals that you identify as important.

- **Case Management and Transition or Discharge Planning**.
  Your primary counselor and/or case manager will work with you to develop a plan that will

assist you to achieve the goals on your personalized Treatment Plan. Transition/Discharge plans will help you to meet your goals and target dates, and keep you informed of your progress towards completion of your program. Your Discharge Plan will help you continue your success upon discharge from our care. This plan may include strategies to continue with your treatment for your substance use disorder, living arrangements that include safe and sober housing, employment options and/or continuing education, and additional services for your family. At your discretion, family members can participate in your discharge planning and will be invited to attend a discharge session at the facility.

- **Consent for Drug Screening or Laboratory Testing**
  Drug Screens may be utilized in your program to monitor and enhance the therapeutic process. By entering re◦MIND's program, you agree to remain free from all mood-altering drugs, including alcohol, while enrolled in the program. In addition, you agree to provide urine samples, breathalyzer analysis, or other laboratory testing upon request as part of your treatment program. Laboratory testing may be able to identify diagnosis of HIV, Hepatitis B or C, or other bloodborne disease. Positive results from this lab work must be reported to the appropriate authorities. I authorize re◦MIND to disclose any reportable infectious disease and information regarding that infectious disease to my local and state health department for purposes of coordinating care. As mentioned previously, your PHI is protected under federal regulations 42 CFR Part 2. If you breach this agreement, re◦MIND is entitled to terminate your participation in the program.

- **Potential Research or Statistical Compilation**.
  As part of ongoing client satisfaction, surveys, and potential future research some information from your file may be submitted to third parties or utilized by re◦MIND. Your identifying information will not be shared; however, general information (age, race, and sex) may be shared.

- **Confidentiality**.
  Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by re◦MIND, LLC. These records will only be released under certain conditions and consents.

- **Informed Consent for Treatment and Participant Agreement**.

  By my signature, I understand and agree to the following:

  - I have read, understand, and have been offered a copy of this Informed Consent for Treatment and Participant Agreement, which includes but is not limited to an explanation of my rights and responsibilities, benefits and risks, complaint/grievance procedure, and confidentiality of my patient record.
  - I agree to participate in the intake and assessment process, and to receive services, which could include assessment, stabilization, detoxification, medication treatment, clinical and medical services, drug screens, discharge planning, and case management services.
  - I agree to follow the Program Rules as discussed.

- I was informed that this consent could be revoked by me verbally or in writing, before or during the period in which I receive services, except to the extent that action has been taken on reliance on it.
- I acknowledge that there have been no guarantees or assurances made to me as the results of services rendered by re◦MIND, or its employees.
- I give permission to contact me for the purposes of obtaining follow up information concerning my progress after completing services.
- I further understand that I have the right to withdraw my consent for assessment and/or treatment at any time by providing a written request to the treating clinician.

Treatment will be conducted within the guidelines of Kentucky substance abuse treatment laws and regulations. I understand that a range of mental health professionals and medical providers, some of whom are in training, provides re◦MIND services. All professionals-in-training are supervised by licensed staff.

This consent will expire after each episode of care.

_____

Printed Name of Client

_____

Signature of Patient Date

_____

Guardian or Legal Custodian Signature (if applicable) Date

_____

Staff Signature and Title/Credential Date

CONSENT FOR TELEHEALTH TREATMENT

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

My healthcare provider and/or re◦MIND has explained to me how the Telehealth technology will be used for my treatment and services.

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

1. I may not need to travel to the consult location.
2. I have improved access to a specialist through this consultation.
3. I have flexibility in scheduling around work, family, and other personal obligations.
4. I receive more efficient screening, evaluation, and treatment.

I understand there are potential risks with Telehealth may include:

1. The video connection may not work due to technical or connectivity issues, or that it may stop working during the consultation, resulting in delays in treatment.
2. The video picture or information transmitted may not be clear enough to be useful for the consultation, resulting in delays in treatment.
3. In very rare circumstances security protocols could fail, causing a breach of privacy or PHI.
4. I may be required to go to the location of the consulting provider if it is felt that the information obtained via Telehealth was not sufficient to make a diagnosis, if state or federal regulations require an in-person session, or my physical presence is required to access specific medications or services.

I give my consent to utilization of Telehealth and being interviewed by the consulting health care provider via Telehealth. I also understand other individuals may be present to assist with technology use, including another healthcare provider and/or tele-presenter, and that they will take reasonable steps to maintain confidentiality of any information obtained. I acknowledge that I have been adequately informed of Telehealth's risks and benefits, and further understand that I have the right to ask my healthcare provider to discontinue use of Telehealth

at any time, but that such a request may result in discharge from care by re◦MIND and its partnering providers.

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

_____

Printed Name of Client

_____

Signature of Patient Date

_____

Guardian or Legal Custodian Signature (if applicable) Date

_____

Staff Signature and Title/Credential Date

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Dear Patient,

Welcome to re◦MIND. We are pleased to be able to provide services to you. Our office is dedicated to excellence in patient care. To maintain our high standards of care, we believe that communication is of utmost importance. Therefore, please take a moment to read and become familiar with the financial responsibilities policies and agreement. If you have any questions, we will be happy to answer them accordingly. We appreciate your understanding.

- **Payment Responsibilities**.
  By accepting treatment from re◦MIND or a partnering healthcare professional, I acknowledge and accept financial responsibility for all charges for all services rendered to me. Before my first session with a re◦MIND partnering provider, I understand that I will be required to provide either my current insurance coverage information and/or a valid credit card.

  While insurance may confirm my benefits, I understand that confirmation of benefits does not guarantee coverage and agree that I am ultimately responsible for any unpaid balance due for services otherwise covered by insurance. It is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network limit, prior authorization requirement, or limitation for services received, and I understand that I must make payment in full for these services that are not covered at the time of service or upon receiving a statement of account from re◦MIND.

  I understand and agree that I am required to update my insurance on file with re◦MIND and/or inform a re◦MIND representative upon any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am ultimately financially responsible for the balance in full.

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

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

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

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

- **Appointments and Cancellations**.
  I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment because the scheduled time slot has been reserved exclusively for me and/or my family members. Repeated missed appointments may result in termination of therapy and enrollment in the program. There may be a time when my therapist or physician or other licensed provider may need to cancel my appointment for an emergency; re◦MIND will make every effort to reschedule me/my family in an appropriate time frame.

I understand and agree to these policies and conditions. I further understand that I have the right to revoke this consent at any time by informing re◦MIND representative(s) or my provider of my desire to do so. However, such revocation shall not affect any treatment, services, disclosures, or obligations already made in compliance with your prior Consent to Treatment. re◦MIND provides this notice to patient to comply with HIPAA, the Centers for Medicare and Medicaid Services, and any applicable State and Federal laws or regulations.

_____

Printed Name of Client

_____

Signature of Patient Date

_____

Guardian or Legal Custodian Signature (if applicable) Date

DEBIT/CREDIT CARD PAYMENT AUTHORIZATION FORM

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from ReMind Health Group including those covered by my insurance. As a convenience, ReMind Health Group will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if ReMind Health Group determines that the cost of my visit will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. ReMind Health Group may deny service or charge a service fee for failure to pay a co-pay or any outstanding balance at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide ReMind Health Group and/or its designated payment agent with my debit/credit card information.
6. I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.
7. I authorize ReMind Health Group and/or its designated payment agent to apply charges to my payment card for all amounts owed to ReMind Health Group, for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
8. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
9. I will not be provided with advance notice of payments authorized hereunder for transactions up to an amount specified by me. I will be provided with a courtesy notification prior to processing any payment in excess of such amount. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
10. I authorize ReMind Health Group and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to ReMind Health Group. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify ReMind Health Group in writing of any changes in my payment or other information.

Cardholder Name as it Appears on Card

Cardholder Email Address

Cardholder Billing Address City State
Zip Code

Phone Number

Cardholder Signature
Date

Credit/Debit Card Information

☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX

Cardholder's Name:
_____

Credit/Debit Card Number: _____-_____-_____-_____

Expiration Date: _____/_____

Security Code: (CVV): _____

Individual's Signature: _____ Date: _____

TREATMENT AGREEMENT

I understand that the goal of Medication Assisted Treatment (MAT) is to suppress my withdrawal symptoms and cravings for my drug of choice. This assistance should allow me to regain a normal state of mind so that I can focus my efforts on making changes in my thoughts, behaviors, and environment to better support my recovery. I understand that re◦MIND's plan may include tapering me completely off medication during the final phase of treatment.

As a patient receiving MAT services, I freely and voluntarily agree to accept this treatment agreement, as follows:

1. I agree to keep, and be on time to, all my scheduled appointments with the prescriber and other providers. Should I miss an appointment, I will call within 24 hours to reschedule another appointment.

2. I agree to conduct myself in a courteous manner in the facility.

3. I agree not to arrive at the facility intoxicated or under the influence of substances. If I do, the provider will not prescribe any medication until my next scheduled appointment.

4. I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without recourse for appeal.

5. I agree not to deal, steal, or conduct any other illegal or disruptive activities in the facility.

6. Any missed visits may result in my not being able to get medication until the next scheduled visit.

7. I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.

8. I agree not to obtain medications from any prescribers, pharmacies, or other sources without informing my treating prescriber. I understand that mixing buprenorphine with other medications, especially benzodiazepines such as Valium and other drugs, can be dangerous. I also understand that several deaths have been reported among individuals mixing buprenorphine with benzodiazepines.

9. I agree to take my medicine as instructed and not alter the way I take my medication without first consulting my prescriber.

10. I understand that medication alone is not sufficient treatment for my disease, and I agree to participate in psychosocial treatment and recovery support services to support my recover. Therefore, I agree to work with my treatment team to create an individualized treatment plan and honor the recommendations that are developed including referral to a higher level of treatment, if warranted.

11. I agree to respect the confidentiality of other patients.

12. I agree to participate in UDS for drug testing at intake and every day that I have scheduled appointments. I further agree to have my blood alcohol level tested.

Dismissal from The Program

I understand that failure to comply with the requirements described above and/or any of the violations listed below may serve as grounds for my discharge from the MAT program:

1. A failed drug screen without advising Provider of the lapse prior to the test.
2. A failed buprenorphine screen could result in my immediate discharge without recourse or appeal.
3. Any attempt by me to alter, substitute, or tamper with a urine specimen obtained for a drug screen will result in my immediate discharge without recourse or appeal.
4. Failure to report for a required drug screen.
5. Distribution of buprenorphine to any other individual will result in my immediate discharge without recourse or appeal.
6. Any alteration, tampering, forging, etc.…of my buprenorphine prescription will result in my immediate discharge from the program without recourse or appeal.
7. Failure to comply with prescribe use of my buprenorphine.
8. Repeated requests to re-schedule appointments.
9. Not showing for scheduled appointments without calling ahead of time to let staff know that I will not be able to make it to my scheduled appointment, may result in my discharge without recourse or appeal.
10. I fail to attend a scheduled case review with the multidisciplinary team.
11. Any illegal activity related to drug or alcohol use may result in my immediate discharge.
12. Any dangerous or inappropriate behavior that is disruptive to the facility or to other patients (this includes reporting to the facility, or any other facility involved in my MAT program) may result in my discharge without recourse or appeal.
13. I fail to make satisfactory payment arrangements for outstanding balances more than $500 or more which is greater than 30 days past due.
14. Need to leave the program due to higher level of care needed.
15. Identified medical or psychiatric issues that require alternative treatment.
16. Any other breach of the terms of this contract.

Discharge from the Program

I understand that I may be discharged from the program(s) thus involuntarily terminating treatment services. I may also voluntarily terminate treatment services. The patient will be issued a discharge notice which stipulates the reason for termination and the anticipated withdrawal time, and which will include the patient's right to appeal (if appropriate). The time for requesting readmission will be specified in the written notice. All discharges are required to

have multi-disciplinary reviews to ensure that that treatment team may give input and offer strategies moving forward before discharge occurs.

Acknowledgement

_____

Printed Name of Client

_____

Signature of Patient Date

_____

Guardian or Legal Custodian Signature (if applicable) Date

Alcohol and Drug Testing Policy

Alcohol and drug testing is the examination of biological specimens (e.g., urine, blood, hair) to detect the presence of specific drugs and determine prior drug use. While there is not a widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment effectiveness and progress to inform treatment decisions. The frequency of alcohol and drug testing should be based on the patient's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued alcohol and/or drug use has been identified to be more common. In general, alcohol and drug testing should not exceed more than twice (2x) a week. If body fluids testing (urinalysis) is performed, the patient's emission of the urine must be collected and observed by an employee with the same gender to protect against the falsification and/or contamination of the urine sample. The treatment facility should take care to be respectful of the patient and patient privacy during the specimen collection process of drug testing.

Decisions about appropriate responses to positive drug tests and relapses should consider:

- The chronic nature of addiction
- That relapse is a manifestation of the condition for which people are seeking SUD treatment
- That medications or other factors may at times lead to false or appropriately positive drug test results.

Alcohol and Drug Testing is allowable at all levels of care. However, alcohol and drug screens may not be covered by an insurance provider. In this case, the patient will be responsible for payment for the alcohol and/or drug screen.

Refusal to consent to an alcohol or drug screen will be recorded as "positive" in the patient's record. Repeated positive alcohol and drug screens can result in a change of treatment planning and possible termination from the program.

Consent for Alcohol and Drug Screens

By signing below, I give consent to re◦MIND and any/all approved employees of re◦MIND permission to take a urine sample from me for the purpose of testing for the presence of prohibited drugs. I understand that refusing to provide or tampering with a urine specimen, may constitute grounds for the termination of my program. As a result, I understand that to maintain the integrity of the specimen, I may be observed by a re◦MIND employee while the urine specimen is obtained. The re◦MIND employee will take care to be respectful of the patient and patient privacy during the specimen collection process.

_____

Printed Name of Client

_____

Signature of Patient Date

_____

Guardian or Legal Custodian Signature (if applicable) Date

Consent for Alcohol Testing

By signing below, I give consent to provide a breath or saliva specimen for the purpose of testing for the presence of alcohol. I understand that failure to participate in this testing will be considered a “positive” test and placed in the patient’s record. Repeated positive alcohol and drug screens can result in a change of treatment planning and possible termination from the program.

_____

Printed Name of Client

_____

Signature of Patient Date

_____

Guardian or Legal Custodian Signature (if applicable) Date

CONSENT FOR THE RELEASE OF INFORMATION
42 C.F.R. PART 2
CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

I, _____ **authorize** _____
(Name of Patient) (Name of Provider)

To disclose the following information:

□ All of my substance use disorder records

or only the following specific types of records as follows:

□ Psychiatric/medical/alcohol/drug abuse evaluation(s).

□ Psychiatric/medical/alcohol/drug abuse discharge summary(s).

□ Progress Notes
□ Psychotherapy Notes
□ Lab Studies/Results
□ Medical tests/studies
□ Medication(s) / Dosing
□ Toxicology Results
□ Diagnostic Information
□ Psychological Testing
□ Educational Testing
□ Other: _____
□ Other: _____
□ Treatment Plans
□ Substance Use History
□ Trauma History

To: _____
(Name of person or organization to which disclosure is to be made)

_____
Address City State Zip Code

_____ _____
Phone Fax

For: _____
(Purpose of Disclosure)

I understand that my alcohol and/or drug abuse records are protected under federal regulations 42 C.F.R. Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent. I may revoke this consent orally or in writing at any time. I understand that the revocation will not be effective retroactively for information disclosures that have already occurred. If not previously revoked, this consent will terminate upon: _____
(Specific date, event, or condition)

Patient's Signature: _____ Date: _____
(If the patient is a minor, only the minor can sign this consent.)

Print Name: _____ Date of Birth: _____/____/_____

Medical Record Number: _____

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: _____

Print Name: _____ Date: _____

Legal Authority: _____

Revocation Section

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Patient Signature: _____ Date: _____

Notice to Recipient of Information

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The Federal rules restrict any use of the information to criminally investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

PATIENT CONFIDENTIALITY AGREEMENT

Dear Patient:

ReMIND is a confidential treatment service and is bound by State and Federal laws of confidentiality of both mental health and substance abuse services. Once an appointment is made, no information can be disclosed to anyone without your written permission on a Release of Information Form. When you come to your first appointment, the policy on confidentiality and your rights as a patient will be discussed in detail.

What this means for you:

ReMIND will not share your information with a third party without your written consent. ReMIND staff will work diligently to protect information provided in treatment sessions.

- Confidentiality does not apply to cases of reported or suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others
- In cases of medical emergency, information may be shared with medical personnel
- On rare occasions, there will be a request by a court for your records. ReMIND may be required to share that information. ReMIND will make an effort to discuss with you any instances where your confidentiality may be breached. ReMIND will make an effort to share only information which is deemed legally necessary.
- Information must be shared with your insurance company, should you choose to use insurance. This information may be seen by various employees of the insurance provider. There is also potential that certain members of your employer may see this information.

Your Responsibility:

It is also your responsibility to protect the confidentiality of other patients. Do not discuss other patients (names, diagnoses, etc.) outside of group therapy sessions. In order to protect your confidentiality, all patients must agree to honor this policy as well. If you are found to have breached this confidentiality policy, you may be discharged from the program.

By signing this form, you acknowledge that there may be instances where ReMIND must share your confidential information and you recognize that you are responsible for helping maintain confidentiality of other patients. Discussing other patients outside of the group sessions may result in your termination from the program.

Patient Signature: _____ Date: _____

MEDICATION ADHERENCE AT REMIND

Medication adherence simply means sticking to the medication prescribed/ordered for you. Adhering to medication is also taking the medication as directed by a health care professional - whether taken in pill form, inhaled, injected, or applied topically.

Not taking medication as prescribed is called non-adherence. Many people never fill their medications, or they may never pick up their filled prescriptions from the pharmacy. Other people bring their medication home, but don't follow their health care professional's instructions - they skip doses or stop taking the medicine.

Specifically, non-adherence includes:

- Not filling a new medication or refilling an existing medication when you are supposed to
- Stopping a medicine before the instructions say you should
- Taking more or less of the prescribed/ordered medicine; or at the wrong time of day

Often there is no single reason someone does not take their medicine as directed, but rather a combination of reasons. One person may face different barriers at different times as he or she manages his or her condition. Whatever the reason, the result is always the same - patients miss out on life -saving benefits, a better quality of life, and lose protection against future illness or serious health complications.

All medicines have risks and benefits. When a patient works with their health care professional to decide to use medicine to help manage a long-term health condition, he or she accepts certain risks in exchange for potential health benefits. Consumers can help manage those risks by using medicines safely, including storing & disposing of them safely.

Importance of Medication Adherence Specifically at ReMIND
Some of the medications prescribed at ReMIND are controlled substances which have an increased requirement for compliance from patients. This is very important because of the health and possible legal consequences associated.

- All patients must take medication EXACTLY as prescribed/ordered.
- Do not attempt to adjust the dose of your medication up or down without consultation of your physician.
- Keep medications in a safe and secure location.
- Theft of medication will not result in an early refill.
- If you have any questions concerning medication, set up an appointment with the nurse practitioner/physician.
- Because of the medication you are taking and a history of substance abuse, it is vital that you coordinate your other medical appointments or surgical/dental procedures that you have with ReMIND. Plan ahead.
- It is important that you tell your primary care physician or any other physician who writes a prescription that you are receiving treatment services at ReMIND.

- DO NOT EVER SELL YOUR MEDICATION OR TRY TO BUY M EDICATION FROM SOMEONE. THIS WILL LIKELY RESULT IN IMMEDIATE DISMISSAL FROM THE PROGRAM AND CAN RESULT IN LEGAL CONSEQUENCES FOR YOU AS A PATIENT.
- NON-ADHERENCE WITH YOUR MEDICATION REGIMEN CAN ALSO RESULT IN RESTRICTIONS BY YOUR INSURANCE COMPANY THAT CANNOT BE RESOLVED BY THE TEAM AT ReMIND. YOU MAY LOSE THE ABILITY TO GET YOUR MEDICATIONS PAID FOR BY INSURANCE.
- BRING ALL MEDICATIONS PRESCRIBED BY REMIND PROVIDERS TO EVERY MEDICAL APPOINTMENT.

Patient Signature: _____ Date: _____

CONSENT TO RECEIVE EMAIL, TEXT MATERIALS, AND CALLS

As a patient of ReMind Health Group, it is important that we be able to contact you using your wireless telephone or email to remind you of appointments, to obtain your feedback on your experience with our healthcare team, to obtain feedback for marketing purposes and to provide you with advertisements or telemarketing messages. We may use an automatic telephone dialing system or an artificial or pre- recorded voice to deliver these messages to you.

By entering your wireless telephone number or email below, you authorize ReMind Health Group, LLC, its employees and its agents, to send emails or text messages, and make telephone calls to that number. You agree that we may use your wireless telephone number or email address to send you information, including healthcare information, advertisements, and telemarketing messages. You also understand that we may use an automatic telephone dialing system or an artificial or pre-recorded voice to deliver these messages to your wireless telephone number.

ReMind Health Group, LLC does not charge for these services, but regular text messaging or incoming call rates may apply. Contact your carrier for pricing plans and details.

You are not required to provide this consent in order to receive services from ReMind.

You may revoke this consent at any time by providing us with notice that you no longer want to receive these communications via your wireless telephone, or by replying “STOP” to any text message or email you receive from us.

You consent to receiving these communications at the following wireless telephone number:

_____

You consent to receiving these communications at the following email address:

_____

Patient Name (Printed): _____

Patient Signature: _____

Date: _____