



NEW CLIENT INFORMATION

DATE: _____ REFERRED BY: _____

FIRST NAME: _____ MI: _____ LAST NAME: _____

AGE: _____ DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

COUNTY: _____ EMAIL: _____

CELL #: _____ HOME #: _____

EMPLOYER: _____ WORK #: _____

RACE / ETHNICITY: _____

GENDER (circle): Female Male Transgender Gender Fluid

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT RELATIONSHIP TO YOU: _____ PHONE #: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

PRIMARY CARE PHYSICIAN ADDRESS: _____

PRIMARY INSURANCE: _____ ID #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ DOB: _____ SOC SEC #: _____

SECONDARY INSURANCE: _____ ID #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ DOB: _____ SOC SEC #: _____

MARITAL STATUS (circle): Single Partnered Married Divorced Widowed

NUMBER OF MARRIAGES: _____ NUMBER OF CHILDREN: _____ AGES OF MINOR CHILDREN: _____

SEXUAL ORIENTATION (circle): Heterosexual Bi-sexual Lesbian Gay Queer Questioning Asexual

FIRST NAME: _____ MI: _____ LAST NAME: _____

HIGHEST LEVEL OF EDUCATION (circle):

HS DIPLOMA GED SOME COLLEGE ASSOCIATES DEGREE BACHELORS GRADUATE DEGREE

OTHER: _____

RELIGION AND SPIRITUALITY:

- NONE
- SPIRITUAL, BUT NOT RELIGIOUS
- PROTESTANT CATHOLIC JEWISH MUSLIM BUDDHIST HINDU (please circle, if appropriate)
- OTHER: _____

PLEASE CIRCLE TO INDICATE THE IMPORTANCE OF RELIGION / SPIRITUALITY IN YOUR LIFE:

NONE SOME IMPORTANCE MODERATE IMPORTANCE VERY IMPORTANT

PLEASE CHECK ALL THAT APPLY:

- | | |
|--|---|
| <input type="checkbox"/> LOW ENERGY LEVEL | <input type="checkbox"/> LOSS OF INTEREST IN HOBBIES / ACTIVITIES |
| <input type="checkbox"/> LOW SELF-ESTEEM | <input type="checkbox"/> DISCOMFORT IN SOCIAL SETTINGS |
| <input type="checkbox"/> SLEEPING TOO MUCH | <input type="checkbox"/> TROUBLE FALLING / STAYING ASLEEP |
| <input type="checkbox"/> SADNESS / DEPRESSION | <input type="checkbox"/> POOR CONCENTRATION OR MEMORY |
| <input type="checkbox"/> RECENT WEIGHT GAIN OR LOSS | <input type="checkbox"/> IRRITABILITY / ANGER PROBLEMS |
| <input type="checkbox"/> PREOCCUPATION WITH BODY IMAGE | <input type="checkbox"/> REPEATED, INTRUSIVE OR UNWANTED THOUGHTS |
| <input type="checkbox"/> WITHHOLDING FOOD / BINGE EATING | <input type="checkbox"/> FREQUENT NIGHTMARES |
| <input type="checkbox"/> PURGING / INDUCING VOMITING | <input type="checkbox"/> EXCESSIVE WORRY / ANXIETY |
| <input type="checkbox"/> RECENT LOSS OF LOVED ONE | <input type="checkbox"/> THOUGHTS ABOUT SUICIDE |
| <input type="checkbox"/> STRUGGLES WITH SEXUALITY (LGBTQ ISSUES) | <input type="checkbox"/> THOUGHTS OF HARMING OTHERS |
| <input type="checkbox"/> STRUGGLES WITH GENDER IDENTITY | <input type="checkbox"/> POUNDING HEART |
| <input type="checkbox"/> ABUSIVE TOWARD OTHERS, MANIPULATIVE | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> COMPULSIVE SPENDING / GAMBLING | <input type="checkbox"/> ADULT INTERPERSONAL TRAUMA (PHYSICAL / SEXUAL / EMOTIONAL) |
| <input type="checkbox"/> RISK-TAKING BEHAVIORS (RISKY DRIVING, SEX, DRUGS, ETC.) | <input type="checkbox"/> CHILDHOOD NEGLECT OR ABUSE (PHYSICAL / SEXUAL / EMOTIONAL) |
| <input type="checkbox"/> REPETITIVE BEHAVIORS (HAND WASHING, COUNTING, ETC.) | <input type="checkbox"/> WORKPLACE TRAUMA (COMBAT, POLICE, FIRE, ACCIDENT, ETC.) |
| <input type="checkbox"/> SELF-HARMING BEHAVIORS (CUTTING, PICKING, ETC.) | <input type="checkbox"/> OTHER: _____ |

SUBSTANCE USE:

IN AN AVERAGE WEEK...

- HOW MANY DAYS A WEEK DO YOU CONSUME ALCOHOL? _____
- HOW MANY DRINKS DO YOU CONSUME IN A GIVEN DAY? _____
- TYPICAL DRINK (BEER, WINE, MIXED, STRAIGHT, ETC)? _____
- HOW MANY DAYS A WEEK DO YOU USE ILLEGAL DRUGS? _____
 - TYPE(S) OF ILLEGAL DRUG(S): _____
- DO YOU TAKE PRESCRIPTION DRUGS OTHER THAN AS PRESCRIBED? Y N

FIRST NAME: _____ MI: _____ LAST NAME: _____

HAVE YOU EVER BEEN HOSPITALIZED FOR THE FOLLOWING REASONS?

- SUICIDAL THOUGHTS, PLEASE PROVIDE DATES: _____
- HOMICIDAL THOUGHTS, PLEASE PROVIDE DATES: _____
- SUBSTANCE ABUSE, PLEASE PROVIDE DATES: _____
- IMPULSIVE BEHAVIORS (RECKLESS DRIVING, SELF-HARM BEHAVIORS, FIGHTING, MANIA)

- VIOLENCE TOWARD OTHERS, PLEASE PROVIDE DATES: _____
- OTHER BEHAVIORAL HEALTH REASONS: _____

ARE ANY OF THESE AREAS OF LIFE STRESSFUL FOR YOU?

- Marriage / Relationship Legal Employment School / Education
- Physical Health Finances Spirituality Family
- Parenting Sex Other: _____

CURRENT MEDICATIONS AND DOSAGES (INCLUDE OVER THE COUNTER MEDICATIONS TAKEN ROUTINELY):

MEDICAL CONDITIONS, PLEASE CHECK ALL THAT APPLY:

- ASTHMA/SEASONAL ALLERGIES/LUNG CONDITION, PLEASE DESCRIBE: _____
- ARTHRITIS
- BARIATRIC SURGERY
- CANCER
- CHRONIC PAIN, PLEASE DESCRIBE: _____
- DIABETES
- DIGESTIVE SYSTEM PROBLEMS, PLEASE DESCRIBE: _____
- FOOD ALLERGIES/SENSITIVITIES/AVERSIONS, PLEASE DESCRIBE: _____
- HIGH OR LOW BLOOD PRESSURE
- HIGH LDL CHOLESTEROL
- HIV/AIDS
- MENOPAUSE
- MIGRAINE HEADACHES
- TACHYCARDIA OR OTHER HEART RATE IRREGULARITIES
- THYROID PROBLEMS
- TRAUMATIC BRAIN INURY, PLEASE DESCRIBE: _____
- OTHER: _____

MEDICAL STATS: HEIGHT: _____ CURRENT WEIGHT: _____

HIGHEST WEIGHT IN PAST 36 MOS: _____ LOWEST WEIGHT IN PAST 36 MOS: _____

IF FEMALE, DATE OF LAST PERIOD: _____ CURRENTLY PREGNANT? Y N UNSURE

FIRST NAME: _____ MI: _____ LAST NAME: _____

HAVE YOU BEEN HOSPITALIZED FOR MEDICAL REASONS IN THE LAST 5 YEARS? Y N

IF YES, PLEASE DESCRIBE: _____

PREFERRED METHOD OF CONTACT:

- Phone (voice calls, not text) - Best number to reach me: _____
- Email
- Postal mail to home address

Contact for Appointment Reminders

As a courtesy, RiverStone Wellness Center routinely sends appointment reminders to clients via email. Please let us know your preference:

- I wish to receive automatic email appointment reminders
- I do not wish to receive automatic email appointment reminders

RELEASE OF INFORMATION

Do you wish to release your RiverStone Wellness Center mental health treatment information to a third party, such as a relative, friend, or agency?

- YES: **Please request a formal *Release of Information* form at your first appointment.**
- NO

By my signature below, I attest that the information provided by me in this document is true and correct, to the best of my knowledge.

Client Signature

Date

Printed Client Name

RiverStone Wellness Center, PLLC

FINANCIAL AGREEMENT POLICY

Thank you for choosing RiverStone Wellness Center for your behavioral health care. The following is our center's statement of financial policy. It is required that all clients read and sign this agreement prior to any treatment.

PAYMENT OF DEDUCTIBLES, CO-PAYMENTS AND FOR ANY NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE. NON-INSURED CLIENTS ARE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, DEBIT, VISA, MASTERCARD, and DISCOVER. A \$35 FEE WILL BE CHARGED FOR ANY RETURNED CHECK. EVENING AND WEEKEND (FRI-SUN) CLIENTS WILL BE REQUIRED TO HAVE A DEBIT OR CREDIT CARD ON FILE FOR BILLING PURPOSES. SERVICE FEES FOR WEEKEND APPOINTMENTS WILL BE PROCESSED ON THE NEXT BUSINESS DAY.

INSURANCE

If your RiverStone Wellness Center provider is in-network with your healthcare company, we will handle your claims according to our agreement with your particular health insurance carrier. You are responsible for paying all co-payments, deductibles, and for any non-covered services on the day of your visit. In the event that we accept assignment of benefits, you are still ultimately responsible for all charges. We do not become involved in disputes with insurance companies. If your insurance plan has not paid within a reasonable time frame, you will be responsible for payment. Our practice is committed to providing the best treatment for our clients and we charge what is usual and customary in our area. You are responsible for your portion of the payment regardless of any insurance company's determination of usual and customary rates. Our standard fees are as follow:

<u>PSYCHOTHERAPY</u>	<u>SW/LPC</u>	<u>PHD</u>	<u>PSYCHOLOGICAL EVALUATIONS</u>	<u>REGISTERED DIETITIAN SERVICES</u>
New client intake evaluation	\$225	\$250	Diagnostic Interview	\$250
New family intake evaluation	\$250	\$275	Psychological Testing	\$200/hour
30-min psychotherapy	\$ 80	\$110		
45-min psychotherapy	\$110	\$145		
60-min psychotherapy	\$155	\$210		
90-min psychotherapy	\$210	\$275		
Group psychotherapy	\$55 per session			
				<i>DIETITIAN SERVICES ARE SELF-PAY (OUT-OF-NETWORK)</i>
				Individual Nutrition Evaluation
				Family Nutrition Evaluation
				Follow-Up Nutrition Counseling*
				Meal Planning
				Grocery Shopping Tours
				Restaurant Trip Sessions

*DISCOUNT PACKAGES ARE AVAILABLE

MINORS

The adult accompanying a minor client is responsible for full payment, regardless of any divorce decree. If the non-accompanying parent/guardian is responsible for a minor's bill, the adult accompanying the minor is responsible for paying the provider's fees and may collect reimbursement from the other parent/guardian. Parents/guardians are responsible for sending payments for services provided to unaccompanied minors at each visit.

AUTHORIZATION TO BILL INSURANCE CARRIER

Your signature below authorizes RiverStone Wellness Center, PLLC to bill your healthcare and/or workman's compensation insurance carrier for all healthcare services provided to you by RiverStone Wellness Center healthcare providers. Your signature also indicates that you agree that RiverStone Wellness Center, PLLC may accept assignment for payment of benefits related to such healthcare services provided, where applicable.

DELINQUENT ACCOUNTS

I agree to be financially responsible for any unpaid balance due to RiverStone Wellness Center, PLLC for services rendered. I understand that, even if I have insurance, some diagnoses may not be covered under my insurance. If this occurs, I agree to pay the full fee for services. I grant permission to RiverStone Wellness Center, PLLC, its agents to discuss my account with, and release any information to, any third-party payer via the US Postal Service, fax, or electronic media in order to assist in the payment of any balance due, or otherwise verify personal information provided. Also, it is understood and agreed that RiverStone Wellness Center, PLLC reserves the right to assess a monthly finance charge, in accordance with Arkansas Law, for any unpaid balance due. Further, it is agreed that should RiverStone Wellness Center, PLLC determine that it is necessary to employ a collection agency to recover any unpaid balance owed, I agree to pay any and all collection fees and costs expended to effect recovery, with such collection fees to be up to 50% of the unpaid balance due, including any and all attorney's fees assessed by any court.

NON-COVERED SERVICES

There will be an hourly fee charged to you based upon the standard fee schedule above, for FMLA, disability, or other forms not filled out during your appointment time. As a general rule, insurance companies do not pay for this charge.

WE ASK THAT YOU PROVIDE RIVERSTONE WELLNESS CENTER, PLLC AT LEAST 24 HOURS NOTICE IF YOU ARE UNABLE TO ATTEND YOUR APPOINTMENT. PLEASE INITIAL BELOW, INDICATING THAT YOU UNDERSTAND AND AGREE TO ABIDE BY THE CLINIC'S CANCELLATION AND NO-SHOW FEE REQUIREMENTS:

_____ I UNDERSTAND THAT I WILL BE CHARGED A \$35 LATE CANCELLATION FEE IF LESS THAN 8 HOURS NOTICE IS PROVIDED, AND THAT I AM FULLY RESPONSIBLE FOR THIS FEE, AS INSURANCE COMPANIES DO NOT COVER LATE OR MISSED APPOINTMENT FEES.

_____ I UNDERSTAND THAT FAILURE TO SHOW UP FOR AN APPOINTMENT WITHOUT ADVANCE NOTICE WILL RESULT IN MY BEING CHARGED THE ENTIRE THERAPY FEE FOR THAT APPOINTMENT, AND THAT TWO MISSED APPOINTMENTS WITHOUT NOTIFICATION MAY RESULT IN DISMISSAL FROM THERAPY.

PLEASE READ THE ENTIRE FINANCIAL AGREEMENT POLICY ABOVE CAREFULLY BEFORE SIGNING. YOUR SIGNATURE INDICATES YOUR AGREEMENT TO ABIDE BY THIS POLICY.

CLIENT (OR RESPONSIBLE PARTY SIGNATURE)

DATE

PRINTED CLIENT NAME

DESCRIBE AUTHORITY OF RESPONSIBLE PARTY



Welcome to Discreet Check Out

Please indicate your preferred method of payment for services:

- American Express
- Discover
- MasterCard
- VISA

Card number: _____

Expiration date: _____ CVC/CVV Code: _____

I authorize RiverStone Wellness Center to automatically process payments for

- my RiverStone Wellness Center account DOB: _____
- the account of _____ DOB: _____

I understand that my credit or debit card referenced above will be charged the agreed upon amount (including health insurance copays, deductible, coinsurance, self-pay amounts, non-reimbursable fees) for services and fees related to clinic appointments. This authorization will remain in effect unless and until I revoke this permission in writing, which I may do without notice.

Name as it appears on card: _____

Card Billing Address: _____

Signature of card holder: _____ Date: _____

FOR OFFICE USE ONLY: CARD IMPRINT ON FILE? YES / NO

RiverStone Wellness Center, PLLC
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT RIVERSTONE WELLNESS CENTER'S NOTICE OF PRIVACY PRACTICES, AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), INFORMS ME OF HOW THIS OFFICE USES AND DISCLOSES MY PROTECTED HEALTH INFORMATION (PHI) AS PERMITTED UNDER FEDERAL AND STATE LAW. THIS NOTICE ALSO OUTLINES MY RIGHTS REGARDING MY PROTECTED HEALTH INFORMATION (PHI).

RIVERSTONE WELLNESS CENTER'S NOTICE OF PRIVACY PRACTICES WAS PRESENTED TO ME TODAY. I ACKNOWLEDGE THAT I HAVE READ THIS AND BEEN OFFERED A COPY OF THE PRIVACY PRACTICES OF RIVERSTONE WELLNESS CENTER, PLLC.

PLEASE SELECT AND INITIAL BELOW:

I HAVE **RECEIVED** A COPY OF THE PRIVACY PRACTICES _____
(INITIALS)

I HAVE **DECLINED** A COPY OF THE PRIVACY PRACTICES _____
(INITIALS)

I ALSO UNDERSTAND THAT PHOTOGRAPHY, VOICE RECORDING, OR VIDEO RECORDING BY ANY METHOD (E.G., SMARTPHONE, CAMERA, TABLET, ETC.) ON THE CLINIC PREMISES IS STRICTLY PROHIBITED IN ORDER TO PROTECT THE PRIVACY OF CLIENTS, GUESTS, STAFF, AND PROVIDERS. BY MY SIGNATURE BELOW, I AM AGREEING TO ABIDE BY THIS POLICY.

CLIENT (OR RESPONSIBLE PARTY SIGNATURE)

DATE

PRINTED NAME OF CLIENT

RiverStone Wellness Center, PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. A new Notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. Copies of this Notice are available from your provider or by mail.

1. Uses and Disclosures of Protected Health Information:

Uses and Disclosures of Protected Health Information for Which Your Authorization Is Not Required. Your PHI may be used and disclosed without your prior authorization by your provider, our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the provider's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, obtaining your medical treatment and history and recording it in your chart and discussing your care with another behavioral health provider to which you have been referred to ensure that the therapist has the necessary information to diagnose or treat you

Payment: Your PHI will be used, and disclosed as necessary, to obtain payment for your health care services. For example, to obtain authorization for your healthcare insurance plan to pay for additional therapy sessions it may be may require that your protected health information be provided to a managed care representative for that determination.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to graduate students who see clients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to identify yourself in some manner and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We will share your PHI with third-party business associates who perform various activities for RiverStone Wellness Center and for your provider. These business associates will have signed HIPAA privacy agreements to strictly protect your PHI. For example, a contract with a collections agency that handles past due accounts.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Opportunity to Object. We may use and disclose your PHI in the following instances. You have the opportunity to object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your health care provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's direct involvement in your health care. If you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for the care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your healthcare provider or another healthcare provider in our agency is required by law to treat you and the healthcare provider has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your PHI to treat you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object. We may disclose your PHI in the following situations without your consent or authorization:

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury, or disability.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration (i) to report adverse events, product defects or problems, biologic product deviations, track products; (ii) to enable product recalls; (iii) to make repairs or replacements; or (iv) to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may disclose your PHI, so long as applicable legal requirements are met, for law enforcement purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may use or disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel: (i) for activities deemed necessary by appropriate military command authorities; (ii) for the purpose of a determination by the Department of Veterans Affairs; or (iii) to foreign military authority if you are a member of the foreign military services.

Workers' Compensation: We may use or disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs. Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your health care provider created or received your PHI in the course of providing care to you.

Fundraising: Though permissible by federal law, we will not contact you for fundraising purposes.

Required Uses and Disclosures: Under the law, we must make disclosures to you, and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with requirements of the Code of Federal Regulations, Part 45 Section 164.500 et seq.

Uses and Disclosures of PHI for which Your Written Authorization Is Required. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your provider or RiverStone wellness Center has already taken an action in reliance on the use or disclosure indicated in the authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; and (iii) other uses and disclosures not described in this Notice of Privacy Practices.

2. Your Rights. Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights:

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of your PHI that is contained in a designated record set for so long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your health care provider and RiverStone Wellness Center uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. You also have a right to restrict certain disclosures of your PHI to a health plan if you have paid in full out-of-pocket for the health care item or service. Your health care provider is not required to agree to a restriction that you may request.

If your health care provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare provider. If your health care provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.

You may have the right to have your provider amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for general notification purposes. You have the right to receive specific information regarding these disclosures. The right to receive this information is subject to certain exceptions, restrictions and limitations.

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

You have a right to receive notifications of a data breach. We are required to notify you upon a breach of any unsecured PHI. PHI is “unsecured” if it is not protected by a technology or methodology specified by the Secretary of Health and Human Services. The notice must be made within 60 days from when we become aware of the breach. However, if we have insufficient contact with you, an alternative notice method (posting on website, broadcast media, etc.) may be used.

3. Complaints. You may complain to us or to the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201, if you believe your privacy rights have been violated by us. You may file a complaint with our Privacy Officer at RiverStone Wellness Center, PLLC, 5905 Forest PL., Ste. 230, Little Rock, AR 72207-5244. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of PHI, to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI.

If you have any objections to this form, please contact our Privacy Officer at RiverStone Wellness Center, PLLC, 5905 Forest Pl., Ste. 230, Little Rock, AR 72207-5244.

This notice became effective on February 9, 2016.



INFORMED CONSENT TO TREAT

RiverStone Wellness Center is dedicated to providing holistic mental health treatment for individuals who have experienced trauma and other challenges. We believe the healing process is unique to each individual. This form is designed to help you understand treatment more clearly so you can take greater ownership of your recovery process.

There are several things we'd like you to know about your care:

Description of Programming:

RiverStone Wellness Center offers several treatment and evaluation options. Clients are not required to participate in all options and, in collaboration with your therapist, you may find that some options will be more beneficial during different phases of recovery.

- Individual Therapy
- Couples / Family Therapy
- Group Therapy
- Psychological Testing
- Nutrition Counseling
- Yoga Classes
- Expressive Arts Therapy
- Wellness Workshops and Retreats
- Massage and Reiki Therapy

Because we are a clinic that focuses on holistic recovery, it is common practice at *RiverStone Wellness Center* for clients to also be encouraged to find ways to (a) increase their physical activity

in ways consistent/safe for their body (b) learn about healthy foods/diet, and/or (c) explore ways to connect with others in meaningful ways.

Psychotherapy Treatment

RiverStone Wellness Center is committed to providing the highest level of treatment. Currently, our center offers all three of the identified gold standard treatments for Post-Traumatic Stress Disorder in adults, including Eye Movement Desensitization and Reprocessing (EMDR), Prolonged Exposure (PE), and Cognitive Processing Therapy (CPT). For those who experience symptoms of Depression, Anxiety, Substance Abuse, and Eating Disorders we offer highly effective, evidenced-based treatments for these experiences as well. Although different in many ways, each of these therapies has strong research evidence supporting its efficacy in reducing symptoms. Our providers can help you find the right process for you to reach your goals, in a very safe and supportive environment.

Psychological Testing and Assessment

Psychological assessments are conducted for a variety of reasons, including diagnostic clarification, qualification for services, and treatment recommendations. A psychological assessment seeks to provide information about a specific question pertaining to psychological, cognitive, or emotional functioning, using empirically validated tools chosen by the clinician. For psychological evaluations, the psychologist will meet for an interview, several testing sessions, and a feedback session to go over the results. These services will also include psychologist's time for the reading of records, the scoring and interpretation of the test results, writing of the report, and any other activities to support these services. The overall time required depends on the nature of the assessment and the consultation question that is being addressed. Reports are generally released to the requesting party or to the individual client when the testing is requested by self-referral. Participation in the assessment process is voluntary and you have the right to ask questions at any point during the evaluation process.

Benefits and Risks of Participation:

Many people experience traumatic events or other symptoms and still live fulfilling lives. Our goal in treatment is to help you along this journey. You may learn that you can live a healthy meaningful

life as well as experience a greater peace of mind. A common report from clients in psychotherapy is that they have decreased symptoms and increased hope. You may also find that small consistent changes lead to a more fulfilling life. As you learn more about treatment and recovery, you may discover that the things you think are helping are doing more harm than good. Please know that increased awareness and significant life changes may cause you some distress as you begin to navigate in a new, healthier way.

One possible risk of treatment is that you may have intense unwanted thoughts, feelings and memories. It is not uncommon to have more intense emotions when you first begin therapy. If you currently avoid these unwanted experiences, therapy will bring you in contact with them more. It is common for these intense feelings *to lessen* as therapy progresses.

Although telling trauma stories is not a part of our PTSD group therapy process, hearing other survivors talk about their recovery experiences may prompt unpleasant thoughts, feelings or memories. Some group members report remembering things that they had not thought about for a long time. Again, it is common for these intense feelings to lessen as therapy progresses.

Alternatives to Participation:

You are not required to take part in programming offered at *RiverStone Wellness Center*. You may seek services outside of *RiverStone Wellness Center* or opt to not engage in any kind of therapeutic services at this time.

What is required to participate in RiverStone Wellness Center programming?

1. You sign the 'Consent to Treat' form (see Appendix A).
2. You understand that taking part in the program is voluntary. You may withdraw from services at any time.

3. If you cannot attend your session, please call the center at 501-777-3200, at least 24 hours before your appointment. Cancellations received less than 8 hours prior to the appointment will result in a \$35 late cancellation fee. Clients who fail to show up for their appointment with no advance notice will be responsible for paying the entire therapy fee for the appointment. Please note insurance companies do not cover missed appointment fees.
4. You are not currently enrolled in other mental health therapy. Different therapies may teach different skills. Taking part in two different mental health therapies at the same time can cause confusion.
5. We expect and encourage you to share information or skills you learn in groups. It is important that you **not** share specific information about other group members.

PLEASE READ THE FOLLOWING CAREFULLY

6. Limits to Confidentiality There are some limits to your privacy.
 - 🗣️ A plan to harm someone else: Your therapist is required to notify the intended victim and the police.
 - 🗣️ A plan for suicide: Your therapist is required to notify the police. If necessary to ensure safety, the therapist may notify family.
 - 🗣️ Report of child abuse or neglect: If you know of a child who is being abused or neglected, your therapist is required by Arkansas law to notify police and social services. If you choose to, you may also report past incidents of personal child sexual abuse with the support of our staff.
 - 🗣️ Report of vulnerable adult abuse or neglect: Arkansas law requires your therapist to notify police and social services of abuse or neglect of a vulnerable adult.

- 🌐 RiverStone Wellness Center utilizes a team approach to treatment, often consulting with one another to provide the best care possible. Please visit our website for a list of our current providers and inform your therapist if there is a conflict of interest.

AFTER HOURS AND EMERGENCY CARE

RiverStone Wellness Center is an outpatient clinic consisting of independently licensed providers whose office hours may vary. Should you leave a message for your provider during their non-business hours, they will return your message during their regular business hours. If you are a new patient and are in need of more crisis management or acute treatment, outpatient care may not be the most appropriate option for you. Should you need acute/crisis care, we may be able to provide a referral for this level of care. Crisis and emergency care is available through your nearest emergency room, by calling 911, or by contacting the National Crisis Lifeline (1-800-273-8255). Other helpful numbers may be found on Appendix B of this packet. If you access emergency mental health services, please contact your therapist for follow-up care.

Appendix A (packet copy)

RiverStone Wellness Center: Consent to Treat

I understand that attendance is important: Showing up for treatment is showing up for yourself. Recovery is possible for those who attend their appointments and work toward positive change in their lives. We understand that some forms of interruptions may be beyond your control (transportation, illness, etc.), however, three missed appointments may result in the treatment protocol being discontinued.

I understand that arriving on time is necessary.

I understand that participation in my sessions is important: Participation includes talking about your progress and doing in-session exercises.

I understand that psychotherapy includes participating between sessions. Participation between sessions is the work you do each week. This includes completing and returning assignments. Practice assignments are designed to enhance your treatment experience.

I have read the 'Informed Consent to Treat' document. I have been given the opportunity to ask questions I may have about this sheet, about the 'Informed Consent to Treat' document.

My signature below indicates that I understand the statements listed above on this sheet.

Client's signature

date

Staff's signature

date

(Keep this copy for your records)

Appendix B

Important Telephone Numbers

Alcoholic's Anonymous	(501) 664-7303
ALANON	(501) 372-5234
Women and Children First <small>(Domestic Violence Shelter)</small>	(501) 376-3219
Child Abuse Hotline	1-800-422-4453
Elder Abuse	1-800-482-8049
Food Stamps/Income Assistance	1-800-252-9330
GLBT National Help Line	1-888-843-4564
Little Rock Police	(501) 918-3900
National Alcohol & Drug Info	1-800-729-6686
Suicide Prevention Lifeline	1-800-273-8255
Problem Gambling	1-800-522-4700
United Way Help Line	(501) 376-4567
VA Hospital	(501) 257-3100
Veterans Crisis Line	1-800-273-8255
Vet Center	(501) 324-6395

Appendix C

RiverStone Wellness Center: Consent to Treat

I understand that attendance is important: Showing up for treatment is showing up for yourself. Recovery is possible for those who attend their appointments and work toward positive change in their lives. We understand that some forms of interruptions may be beyond your control (transportation, illness, etc.), however, three missed appointments may result in the treatment protocol being discontinued.

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I have read the 'Informed Consent to Treat' document. I have been given the opportunity to ask questions I may have about this sheet, about the 'Informed Consent to Treat' document.

My signature below indicates that I understand the statements listed above on this sheet.

Client's signature	Date	Staff's signature	Date
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(Return this signed copy to your provider)