CLIENT INFORMATION & FINANCIAL POLICIES CONSENT FORM

CONSENT TO RECEIVE ELECTRONIC NOTIFICATIONS VIA EMAIL OR TEXT MESSAGE

Sagent Behavioral Health is able to send electronic notifications to your email address and/or as a call/voicemail/text (if you have texting capability; available for most cell phone providers) to your phone. Please be aware of any costs associated with texting to your mobile phone- check with your mobile service provider if you have questions before agreeing to receive text messages.

An email, text message or phone call/voicemail would arrive to your email or phone and may include things like appointment reminders or notifications about your account. Caller ID and email address may show Sagent or Sagent Behavioral Health. If you agree now, you can always opt out of electronic notifications in the future by following the instructions in the email or text message, or by calling our office.

By signing at the end of this document, I authorize Sagent Behavioral Health to send electronic notifications to the email address(es) and phone numbers that I have provided as indicated in the Client Information section above, including delivery of SMS/MMS text messages using an automatic telephone dialing system. I understand that I am not required to opt-in to receiving text messages as a condition of receiving services from Sagent Behavioral Health

*Please let us know if any of this information changes to ensure message delivery.

CLIENT ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT OF SERVICES

I authorize Sagent Behavioral Health to release any medical information to my insurance company that may be deemed necessary in order to process an insurance claim. It is my intent that a copy of this authorization carries the same force and effect as the original. I certify that the information provided on this form is correct to the best of my knowledge. I authorize my insurance company to assign benefits to Sagent Behavioral Health.

I agree to notify immediately any representative with Sagent Behavioral Health whenever there are any changes to my health condition and/or health insurance plan coverage. I understand that I am ultimately responsible for payment to Sagent Behavioral Health for any and all services rendered to me at the time of my visit; this includes deductible balances, co-insurance and co-payments. I also understand that if I suspend or terminate my care and treatment for any reason, or if my group or individual health insurance plan does not cover my treatment or is terminated during the course of my treatment, I am responsible for any uncovered or ineligible charges and/or unpaid balance. I accept full responsibility for my treatment, and I release Sagent Behavioral Health and all members of the Sagent Behavioral Health staff from any and all liability in the unlikely event that a problem arises from my treatment. I acknowledge that this contract agreement is between my health insurance carrier and me, not Sagent Behavioral Health. I have obtained pre-authorization from my insurance company, if preauthorization is a requirement to receive benefits.

By signing at the end of this document, I affirm and certify that the above information is complete and accurate to the best of my knowledge.

FINANCIAL POLICIES ACKNOWLEDGEMENT AND AGREEMENT

PRIVATE PAY: You are considered to be a 'Private Pay' client until you provide Sagent Behavioral Health with your completed insurance information to determine your qualification and acceptance of health insurance coverage. All payments are due at the beginning of each session. Sagent Behavioral Health accepts cash, checks, or credit cards (MasterCard, Visa or American Express). Sagent Behavioral Health offers sliding fee scale options for most of the services that we provide. In order to determine your eligibility for reduced rates of services, Sagent Behavioral Health will ask you about your income and ability to pay during the intake session.

CREDIT CARD ON FILE REQUIRED: To streamline billing and payment and provide a convenient way for patients to pay their bills, Sagent Behavioral Health requires all patients keep an active credit card on file with us. If your credit card on file needs to change, please notify us immediately. All payments are due at the beginning of each session where appliable, including co-payments, or immediately upon receipt of any billing statement. Circumstances when your card on file would be charged, for which you acknowledge that you are authorized to give consent, include but are not limited to: missed or canceled sessions without 24-hour notice; unpaid co-payments, coinsurance, and/or other out-of-pocket payments; and any other payments owed for non-covered services and/or denial of services by insurance. If a client has not arrived within 15 minutes of the scheduled appointment time, the appointment may be considered a No-Show. Any missed appointments in which 24-hour prior notice was not given may be charged a Late Cancel Fee of $85. Any missed appointments in which no prior notice was given may be charged a No-Show Fee of $100. *Sagent will not bill a client with MA or PMAP insurance a no show or late cancel fee.* Missing two intake appointments in a row may result in discharge from services. You hereby give consent to charge the credit card you have provided, or bill you directly for these charges.

BILLING STATEMENTS: For the purpose of ensuring secure and convenient access, Sagent is authorized to transmit a copy of your billing statement to the activated portal. You retain the option to withdraw this consent at any time by providing written notification.

IDENTIFICATION AND INSURANCE SUBMISSION FOR OUR CLIENTS: Sagent requires a copy of your insurance identification card and driver's license for all clients, especially those with current health insurance coverage that would like our business office to submit claims on your behalf.

TELEPHONE/TEXT CONSULTATIONS: Telephone/Text conversations with your clinician other than setting an office appointment time, are considered an "office visit" and you may be charged a prorated hourly fee. Please not that while therapeutic services may be offered via telephone or video exchange, insurance may not cover the cost of these services. Additionally, therapeutic services are not to be conducted over text messaging or other electronic exchange unless specifically addressed in the treatment plan and both the clinician and client agree to terms regarding electronic exchanges.

PREPARATION OF FORMS AND REPORTS: Should you request forms or reports to be completed on your behalf, we will assist you in the process. Completion of forms or reports requires that a provider review a patient's chart and often will require a discussion with the client. There is a minimum charge of $35 up to a maximum of $250 per hour.

COURT APPEARANCES: Due to the confidentiality of the client-provider relationship The provider does not typically testify in court without a court order requiring them to do so. In such cases, the provider will be monetarily compensated as set forth below.

Unless otherwise limited by law, the client agrees to pay the provider for his or her time preparing for and testifying, including travel, and necessary expenditures (copies, parking, meals and the like) at the following rates: The cost for a therapist to appear in court/arbitration or at a deposition is $250 per hour, rounded to the nearest half hour, for a total of two thousand ($2000) dollars per a maximum 8-hour day. The cost for a medication management prescriber to appear in court/arbitration or at a deposition is $400 per hour, rounded to the nearest half hour for a total minimum of three-thousand two hundred ($3200) dollars per a maximum 8-hour day.

The client further agrees to pay the minimum charge amount(s) outlined above two weeks prior to the appearance, presentation of records or testimony requested. If the hearing is cancelled, the client must notify the provider as soon as they know, and the client will be reimbursed up to half of the fees, excluding any time already incurred. Unless otherwise specified in writing, the providers of Sagent Behavioral Health do not agree to provide services as expert or forensic witnesses, and any oral or written communication or testimony required and/or provided by them will be limited to factual information only.

RETURNED CHECKS: We will gladly accept your check for our services. However, you will be charged $30 for a returned check. Thereafter, payment must be made either with cash or credit card.

CANCELLATIONS & NO-SHOWS: Any missed appointments in which 24 hour prior notice was not given may be charged a Late Cancel Fee of $85. Any missed appointments in which no prior notice was given may be charged a No Show Fee of $100. I hereby give consent to access my credit card or to bill me directly for these charges.

By signing at the end of this document, I attest that I have read and understand the above policies.

CLIENT INFORMED CONSENT FOR TREATMENT & NOTICE OF PRIVACY PRACTICES

CONFIDENTIALITY

Issues discussed in therapy are important and are ordinarily protected as confidential and/or "privileged." However, there are limits to the rights of confidentiality and privilege, and in some situations, we may be required to disclose otherwise confidential or privileged information and/or records even if you do not authorize us to do so. These situations include but are not necessarily limited to when:

1. We have reason to believe that there has been abuse or neglect of a child, elderly person or a vulnerable adult.
2. We have reason to believe that you are in danger of harming yourself or another person or you are unable to care for yourself.
3. You are in possession of a firearm, and we have reason to believe you are at risk of harming yourself or another person with this firearm.
4. We receive a court order, subpoena, or other legal process requiring us to disclose otherwise confidential or privileged information and/or records.
5. We are required by your insurance company or other third-party payor to disclose information and/or records in order to, for example, process a claim for reimbursement or coverage, respond to an audit, or facilitate a case review or appeal.
6. We are required by a licensing board or other regulatory authority to disclose information and/or records.
7. We are otherwise required by any federal, state or other statute, rule, order or other law to disclose the information and/or records.

Due to Minnesota Regulatory requirements and the value Sagent Behavioral Health places on case consultation and quality client care, your therapeutic and rehabilitative sessions may be observed by peers and/or supervising staff. You will be consulted, and consent will be requested before any shadowing or observation takes place.

AUTHORIZATION OF USES AND DISCLOSURES OF CLIENT INFORMATION: I authorize Sagent Behavioral Health to collect, use, and share my information, including Protected Health Information ("Information") as provided below.

DESCRIPTION OF INFORMATION TO BE RELEASED: I understand that my Information includes, but is not limited to: (a) my personal information (i.e., address, age, etc.); (b) information that I have provided to Sagent Behavioral Health regarding my medical condition or diagnosis including without limitation, medical and mental health treatment information, prior treatment records, identification of healthcare providers; (c) information I have provided when completing forms or authorizations; (d) insurance or financial information; and (e) Information collected through my treatment with Sagent Behavioral Health.

PURPOSES FOR USE OR RELEASE OF INFORMATION: I understand that by completing this authorization, I am consenting to Sagent Behavioral Health using and disclosing my Information for the following purposes: (a) to assist me in obtaining and accessing mental health related services; and (b) to provide you with information, including marketing communications, regarding the mental health services offered by Sagent Behavioral Health.

TREATMENT NOT CONDITIONED: I understand that completing this authorization is voluntary and that Sagent Behavioral Health will not deny me treatment or services based on my completion of this authorization.

EXPIRATION OF THIS AUTHORIZATION: This authorization will expire one year after my last treatment through Sagent Behavioral Health.

REVOCATION OF AUTHORIZATION: I understand that I may revoke (cancel) this authorization at any time by sending a signed, written request to: Compliance@elliementalhealth.com.

I understand that any revocation of this authorization will not be effective with respect to information that has already been used and/or disclosed pursuant to this authorization. Information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal and state law. I understand that I can obtain a copy of this authorization upon request.

By completing this authorization, I authorize Sagent Behavioral Health to use and disclose my Information for the purposes provided herein.

CLIENT NOTICE OF PRIVACY PRACTICES

Please review Sagent Behavioral Health's Notice of Privacy Practices found on its website.

If client is a minor, by signing this document, you consent to Sagent uploading any applicable divorce decree/custody agreement to the minor's electronic health record.

If you believe that your privacy has been compromised or if you are seeking more assistance regarding your personal health information, we ask that you first contact Sagent Behavioral Health's Compliance Department by email at: compliance@elliementalhealth.com or by phone at: 651.313.8080

SAFETY
To maintain a secure environment, no weapons are permitted on the premises of our mental health facility. This includes firearms, knives, or any potentially harmful objects. However, law enforcement officers are an exception to this policy, recognizing their duty protocols for public safety. In the interest of safety, providers may stop a session at any time or call for assistance if weapons are found in violation of this policy.

CLIENT NOTICE FOR FILING A GRIEVANCE

The nature of the services provided by Sagent Behavioral Health are voluntary. If at any point in the relationship with your provider, you are unhappy or feeling uncomfortable you are encouraged to first contact Sagent Behavioral Health supervisors to talk about your concerns. Sagent Behavioral Health supervisors want you to be happy with your services and encourage open communication to help ensure your wellness needs are being met.

In addition to reaching out to Sagent Behavioral Health as a first means of filing a complaint you are also able to file a formal grievance. A copy of our grievance process has been given to you for your review and can be found on our website.

RELEASE OF RECORDS

All client information is considered strictly confidential (subject to limitations authorized or required by law) and will not be given out to anyone without your prior written consent or other legal authorization. In the event of a request for copies of or a transfer of client records, the records will be forwarded only after receipt by Sagent Behavioral Health of proper signed written authorization from the client or other authorized persons. Please note that email and text communication is not secure and therefore confidentiality cannot be guaranteed.

CLIENT RIGHTS TO AMEND RECORDS

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), clients have the right to request an amendment to their clinical records if they believe the information is inaccurate or incomplete. All amendment requests will be responded to in a timely manner as required by HIPAA regulations. Requests must be made in writing and may be denied under certain circumstances, which will be communicated to the client in writing.

RECORDINGS

Sagent Behavioral Health does not permit audio, video or other electronic recording by clients of any services provided without the express written permission of an authorized representative of Sagent Behavioral Health. Any violation of this policy may result in immediate termination of the services being provided.

Sessions conducted by student interns may include recording of sessions for use in supervision. These recordings may not be used for any purpose other than for use in supervision, are stored on a password protected device and are destroyed at the termination of services. Sagent Behavioral Health's recordings of any kind are limited to sessions where the client has provided explicit consent to do so.

AFTER-HOURS EMERGENCIES

Sagent Behavioral Health providers are not available for after-hours emergencies. Messages are checked on weekdays during the hours of 8:00 am and 7:00 pm. To leave a message, call your provider directly or call our main office. For after-hours emergencies or if you need immediate assistance, call 911, your medical group or primary care physician.

CLIENT RIGHTS AND CONSENT FOR SERVICES

Sagent Behavioral Health does not discriminate based on race, color, national origin, creed, religion, sexual orientation, public assistance status, marital status, age, disability, or sex, including sex stereotypes and gender identity. Please also reference Minnesota Patients' Bill of Rights and Minnesota Client Rights & Protections. A copy of these rights are located in every Sagent Behavioral Health location and can be found on our website.

When engaging with Sagent on social media, please be aware of potential risks related to the disclosure of confidential information. The nature of social media platforms may present challenges to confidentiality. We cannot guarantee the confidentiality of information shared through these channels. For matters requiring discretion, consider using more secure communication methods.

You have a right to receive a Good Faith Estimate, which is an estimate of the cost of services, upon request. This estimate will provide you with an understanding of the potential financial commitment involved in receiving our services.

Please note, if you would like Sagent Behavioral Health to have a copy of your healthcare directive, you are responsible for providing this information. This is not a requirement but can be helpful in providing the best treatment in case of emergencies.

MINOR CONSENT FOR SERVICES

Per Minnesota Law, a minor who is age 16 to 17 has the right to give effective consent for outpatient mental health services. Minors who choose to consent for their own services independently will follow standard protocol for adult clients, which includes maintaining confidentiality. However, confidentiality may be breached if required by law or if there is a concern that the client may harm themselves or others. Clinicians may use their clinical judgment to determine if a client at this age is not capable of consenting to their own services. By signing below,

you agree to assume financial responsibility if the minor client chooses to consent to their own services.

PRE-LICENSED PROVIDERS
Some of our healthcare providers are currently in the process of working towards licensure and are under the supervision of a qualified professional. As a result, they may consult with their supervisor regarding your case to ensure the highest standard of care. Additionally, your billing statement may reflect the name of the supervisor rather than the individual provider. This practice aligns with regulatory standards to maintain the quality and oversight required during this developmental phase of their professional journey.

I have read and understand the above policies. I further understand that the information I have furnished is to be used for management purposes and the agency will ensure confidentiality. I understand that it is my responsibility to read and understand the policies for all services whether I am attending now or ever attend these services in the future. I may inquire about or object to the methods and/or type of information stored. My rights are protected under the State and Federal Confidentiality laws and any release of information requires my consent except where required and permitted by law, including child abuse and/or neglect and the intent to harm others or myself. I give my consent to Sagent Behavioral Health to provide evaluation, treatment and/or other services that we mutually determine to be appropriate. I am participating voluntarily and I understand my right to refuse or discontinue treatment at any time. I have had the opportunity to discuss my reasons for seeking services and I understand my responsibilities in the therapeutic relationship.

By signing at the end of this document, I attest that I have read and understand the above policies.

TELE-HEALTH INFORMED CONSENT

I consent to engaging in tele-health with Sagent Behavioral Health, as a part of the therapy process and my treatment goals. I understand that tele-health psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Tele-health will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

I understand I have the following rights with respect to tele-health:

1. I have the right to withhold or remove my consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefit to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply to tele-health. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the tele-health interaction to other entities shall not occur without my written consent.
3. I understand that there are risks and consequences from tele-health including but not limited to, the possibility, despite reasonable efforts on the part of Sagent Behavioral Health that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that tele-health-based services and care may not be as complete as in- person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to a mental health professional who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.
4. I understand that I may benefit from tele-health services, but that results cannot be guaranteed or assured. I understand that the use of Skype, FaceTime, GoToMeeting, and Google audio/video systems are not 100% secure and may have issues with wifi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for tele-health services. I will not hold Sagent Behavioral Health or its staff liable for the gathering or use of client information by these service providers.
5. I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.
6. I understand that my therapists' ability to provide out-of-state teletherapy to me may be dependent on that state's licensure requirements and/or my insurance requirements. I agree to keep my therapist updated if I plan to engage in therapy outside of the state in which my therapist is located.
7. By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that an emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are

not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Hotline at 988.

By signing this document, I attest that I have read the consent forms and understand the above policies. I acknowledge that I have received a full copy of the **Client Bill of Rights** and **Sagent's grievance process** for my review.

If I have **not** received these documents, or if I have any questions about the information provided, I understand that I should **not sign** this form and should contact my provider or Sagent Behavioral Health for clarification.

If client is a minor, parent/guardian MUST sign below. Minor signature is not valid.

X _____ _____

Signature of Client/Parent/Guardian Date

*If you are a parent/guardian, by signing this, you attest that you have legal custody of your minor child and have legal decision-making capabilities.