NOTICE OF GENERAL CONSENT TO TREAT, PRIVACY PRACTICE, HIPAA DISCLOSURE, AND PRACTICE POLICY & PROCEDURES

This Notice of Privacy Practices describes how we may use and disclose your protected health information 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" 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 our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION AND POLICY & PROCEDURES

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

CONSENT FOR TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

CONSENT FOR REMOTE/VIRTUAL TELEHEALTH TREATMENT: In addition to on-site treatment, we offer remote/virtual telehealth treatment. To receive telehealth services, I understand, acknowledge, and agree to the following restrictions: 1) limitations, risks, expectations, and my responsibility in complying to treatment and crisis intervention by 3rd party crisis intervention team and/or local police, 2) establish and maintain confidentiality during my electronic communication during treatment session, 3) provide address of current location when treatment begins and my contact information in event of loss communication, 4) in the event of an emergency or crisis, I will contact and/or be contacted by crisis team and/or police, 5) confirm my identity at the start of each telehealth treatment session, 6) conduct telehealth treatment session in a space or room free of another person present able to witness or hear session details, unless otherwise requested by provider, and 7) maintain personal responsibility of compliance to treatment and care deemed appropriate by provider.

CONSENT FOR MINORS: I understand that, for minors entering treatment, decisions about psychiatric, other behavioral health and medical care must be made by the child's legal guardian(s), who must have an opportunity to be fully informed of the evaluation process and treatment recommendations and options.

CONSENT FOR MINORS OF DIVORCED/SEPARATED PARENTS: In the situation of a parental separation or divorce (except in the case of one parent having sole physical and legal custody), both parents must consent, in writing, to the psychiatric evaluation, and both parents are invited and encouraged to participate in the process of evaluation and treatment. If one parent retains sole physical and legal custody, this parent must provide legal documentation of this in order for the psychiatric evaluation to occur as scheduled. Both parents, regardless of custody, have a legal right to medical records. Custody documents are required and must be presented prior first appointment.

CONSENT TO OBTAIN MEDICATION HISTORY: I agree that clinic may request and use my prescription medication history from other providers, state databanks, pharmacies, and/or third-party payers for treatment purposes.

REGISTRATION: All clients or the client's legal guardian will be provided with a copy of this written policy regarding the clinic's registration procedures, no show/cancellation policy and procedures, billing policies, termination policy, and the client or their legal guardian will accept the terms and conditions by signing an acknowledgment of all clinic practices.

Insurance coverage will be verified as a courtesy for clients who have insurance coverage, prior to the first appointment. If any coverage issues are found during insurance verification, TMS Services of Vancouver will communicate the information to the client prior to their visit. However, the ultimate responsibility for verifying coverage rests with the client. Benefit information obtained from the insurance company and/or authorization(s) are not a guarantee of payment to TMS Services of Vancouver. Any charges not paid by the insurance company will be the financial responsibility of the client. Any changes in insurance, deductibles, and/or co-pays are the responsibility of the client. It is not the responsibility of TMS Services of Vancouver to review the balance of any deductibles, changes in insurance or insurance information, or coordination of benefits. Any charges incurred due to, but not limited to deductibles, loss or change of insurance, or failure to coordinate benefits will be the client's financial responsibility. If authorization for services is required with the client's insurance, TMS Services of Vancouver will retrieve authorization for the initial services. It is the responsibility of the client to request that TMS Services of Vancouver obtain additional authorizations after the initial authorization has lapsed and/or all visits authorized

have been used. If the client fails to notify TMS Services of Vancouver or fails to retrieve authorization for the services and authorization is not obtained, any charges incurred that the insurance company denies due to lack of authorization will be the financial responsibility of the client.

Co-pays, deductibles, or any outstanding amounts on the client's account are due and payable prior to the client's appointment and will be collected prior to services being rendered; a follow-up appointment will not be scheduled if there is a balance due, UNLESS the provider determines that the client is in an emergency situation, in which case, a follow-up appointment will be provided and the client will be given a 30-day written termination notice. An outstanding balance on the client's account includes no show and/or late cancellation fees that have not been collected.

New clients will be provided a written statement regarding the clinic's billing policies, termination policy, and no-show/cancellation policy; they will sign this statement to indicate they have read it and acknowledge the clinic's operating practices. The client may receive complete copies of these policies, at his/her request. It is the client's responsibility to read the policy.

NONSECURE COMMUNICATION: I understand that conventional voicemail, email, text/SMS, and video chat may not be fully secure, and that I have a right to use either secure or nonsecure methods of communication. I agree to inform clinic if I DO NOT allow nonsecure communications. I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that my chosen methods of communication do not affect whether I can receive treatment. I also understand that I may terminate this authorization at any time. I understand that if I initiate such communication (e.g. by texting or email) that consent for reciprocal communication by clinic is implied.

LIMITATIONS ON INSURANCE COVERAGE: I understand that clinic will make good-faith attempts to verify my insurance coverage as a courtesy when possible prior to my first appointment and any coverage issues will be communicated to me; however, I understand that this is not a guarantee of coverage and any charges not paid by the insurance company may be my responsibility including deductibles, copays, disallowed charges, and adjudicated amounts. If prior authorization for services is needed, I understand that it is my responsibility to notify clinic in advance and that charge denied due to lack of authorization may be my responsibility.

PATIENT/GUARDIAN RESPONSIBILITY FOR PAYMENTS: I agree to pay any charges due including copays, deductibles, and outstanding balances prior to each visit, and understand that I may not be scheduled for follow-up appointments while there is a balance due; if I am seen emergently while in arrears, I understand that I may be given a 30-day termination notice at the discretion of the provider and clinic.

CONSENT TO MAINTAIN AND CHARGE CREDIT/BANK ACCOUNT ON FILE: I hereby authorize clinic to charge my credit card or debit my banking account for balances that are over 30 days due, to charge regular office visits at the time of service unless I pay by other means, and to charge for missed appointments according to standard policy as discussed below. I agree that my credit card or banking information will be kept securely on file, and I further agree that, in the event my credit card becomes invalid, I will provide a new valid credit card upon request to be charged for the payment of any outstanding balances owed.

SELF-PAY AND OUT-OF-NETWORK BENEFITS: I understand that I have a right to self-pay for my care and forgo insurance coverage. I agree NOT to file out-of-network claims to insurers with whom clinic is an in-network contracted provider. Clinic can provide a 'superbill' to be filed by patients with out-of-network insurers.

NONCOVERED SERVICES: I understand that some specialty, intensive, comprehensive, alternative, experimental, and other services may not be covered by insurance and are offered on a fee-for-service basis due prior to treatment. This will be made clear by clinic prior to provision of service. I understand that clinic will provide a standard receipt on request but not a superbill, and I will not seek insurance reimbursement unless explicitly allowed by my provider.

AHCCCS/MEDICAID: I understand clinic is not a designated AHCCCS/Medicaid provider and hence do not bill AHCCCS/Medicaid for services rendered. I agree to be financially responsible for all patient responsibility payments not covered by the primary insurance. I understand I will not be seen if and/or when AHCCCS/Medicaid becomes my primary insurance. I understand clinic only accepts AHCCCS/Medicaid as a secondary insurance and I must have a primary commercial insurance plan that is non-AHCCCS/Medicaid based. I agree to disclose to clinic if I have AHCCCS/Medicaid and, in the event that I don't, I understand that I will be discharged.

MEDICARE: I understand clinic is not a designated Medicare provider and hence do not bill Medicare for services rendered. I agree to be financially responsible for all patient responsibility payments not covered by the primary insurance. I understand I will not be seen if and/or when Medicare becomes my primary insurance. I agree to disclose to clinic if I have Medicare and, in the event that I don't, I understand that I will be discharged.

COOPERATION WITH ONLINE PATIENT PORTAL ASSIGNMENTS: I will establish a secure patient portal account through the clinic's Electronic Medical Record (EMR). I am responsible for completing assignments indicated by my provider prior to each visit. If assignments are not completely prior to appointment, I understand and acknowledge that I may not be seen and a potential NO SHOW fee to be charged to me. I understand that, if I arrive 45 minutes prior to the session, it may be possible to complete the assignments at the clinic provided that a computer is available.

DISABILITY, FMLA, AND OTHER FORMS: I understand that clinic and its providers are NOT obligated to fill out disability and other such paperwork. No disability forms will be filled out for patients in treatment less than 90 days and less than 3 encounters. When forms are filled out at the provider's discretion, there will be a minimum charge of $20 per page. Please note rates and policy subjected to change without notice.

COURT AND LEGAL SERVICES: I understand that clinic and its providers do not work with forensic matters or court-ordered treatment. If subpoenaed to testify or appear in court all related costs and time spent on the matter will be billed to the responsible attorney. Please note rates and policy below subject to change without notice. Court and legal services subject to different and higher rates and restrictions.

CONTROLLED SUBSTANCES: I understand that clinic and its providers are NOT obligated to dispense medications that they see as potentially harmful, particularly controlled substances such as stimulants (Adderall, Ritalin), benzodiazepines (Xanax, Valium, Klonopin), or narcotic pain-killers. Generally, such prescriptions are not dispensed at the first several meetings, even if they were started by an outside provider; referrals to appropriate detox facilities will be made if indicated. Urine toxicology may be required as a condition of receiving prescriptions for certain medications.

PROHIBITED ITEMS: I understand that no firearms, vaps/e-cigarettes, weapons, illicit substances, or alcohol may be brought onto the premises, and that violations may be grounds for immediate termination and prosecution.

LABORATORY TESTING: I understand that certain medical conditions can cause psychiatric symptoms, and some psychiatric conditions and medications require laboratory monitoring for safety. Complying with provider orders for laboratory tests (either going to a lab or providing recent results ordered by another provider) is a condition of treatment, and treatment may be terminated for repeated non-adherence.

REFILLS: It is the client's responsibility to make refill requests 7 days before running out of medications. Urgent refills are only filled at the discretion of the provider.

SUPERVISORY RELATIONSHIPS: I understand that in some cases unlicensed providers or therapists may provide treatment under a supervisory relationship with a licensed provider, and that clinic will inform patients of such circumstances prior to treatment by an unlicensed practitioner, trainee, etc. I understand that I have a right to refuse treatment, but that alternative licensed providers may not be available.

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION USED FOR RESEARCH: I acknowledge and understand that clinic on occasion do participate in research projects and can use my demographical and clinical information for research purposes only. I understand my data used for research will be de-identified and will be combined with other people's data. My clinical data will be aggregated with other datasets, data points, and databases to generate statistical information for the sole purpose of research and academic reasons. I understand that my personal health information will never be published. I understand the research will not interrupt or interfere with my ongoing or existing treatment. I understand that certain research projects may offer compensation for select participation.

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION USED FOR EDUCATIONAL AND/OR TRAINING PURPOSES: I acknowledge and understand that clinic on occasion do participate in educational and/or training of professionals and can use my demographical and clinical information for teaching purposes only. I understand trainees are trained to understand and subject to follow strict guidance of clinic HIPAA and PHI policies. I understand this will not interrupt or interfere with my ongoing or existing treatment.

TERMINATION: I understand that I may terminate treatment at any time and request that their medical records be sent to another provider. clinic may terminate treatment for reasons including but not limited to: it is determined that inadequate expertise or facilities are available to treat the condition; a higher level of care is required (eg intensive outpatient, residential, or hospital-based treatment) for safety or acuity; the agreed upon treatment plan is not adhered to due to poor and/or lack of treatment compliance; withholding or misrepresentation of important information; misuse of prescribed medication; multiple no-shows or cancellations; failure to satisfy payment of outstanding bills; repeated failure to pay for service; or threatening, obscene, belligerent, or otherwise disruptive behavior. Written notice of termination with a 30-day period with referrals to other community providers is generally offered except in cases of gross non-adherence or inappropriate behavior that do not allow for any ongoing productive treatment relationship. I understand it is the discretion of the admitting provider, clinical director, and/or medical director, to allow reactivation and re-enrollment back into clinic services.

EMERGENCIES: Our clinic and its subsidiary locations DO NOT manage acute crisis and psychiatric emergencies. If you are experiencing a true emergency, please dial 911. Messages left on our voicemail will be answered within one business day (or next business if. Message received after Friday closing). Matters requiring a call back may be left with voicemail menu to be triaged by a staff member; only truly urgent calls will be forwarded to the physician on call. Help can also be sought from:

Crisis Lines:
National Suicide Crisis Hotline: 800-273-TALK
Maricopa County Crisis Response Network: 800-631-1314 or 602-222-9444
Empact Crisis: 480-784-1500

PAYMENT: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

NO SHOW/LATE CANCELLATION POLICY: Clients who fail to show for an appointment or do not provide 24-hour notice of cancellation will be assessed a non-negotiable administrative fee to be applied to appointment scheduled. TMS Services of Vancouver can be reached at all times for greater than 24-hour cancelling and/or rescheduling appointments at 480-565-6440; a message may be left on a business day. Please note that a message left on the weekend may not count toward the 24-hour notice.

Fees include $150 (intakes) and $75 (follow-up) to be applied to appointment scheduled. Please note rates subject to change without notice.

No show/late cancellation fees are not negotiable. Any exceptions to policy require approval by clinic management.

If client has multiple incidences of no-show and/or late cancellation (within 24-hour notice), services to client will be terminated effective 30 days from mailing date of notice. Any exceptions to policy require approval by clinic management.

BILLING AND PAYMENT POLICY: Residual amounts due after insurance adjudication will be billed directly to the client and are the client's financial responsibility. Payment is due prior to services being rendered.

If a refund is owed to the client, the refund will be paid within approximately 6-8 weeks of adjudication.

TMS Services of Vancouver bills the client's insurance company as a *courtesy* to the client. The client's insurance benefits are a contract between the client and the client's insurance company. It is the client's responsibility to verify their mental health benefits. If benefits are exhausted, the client is liable for all charges incurred. Whatever disagreements the client has with his/her insurance company including benefit information; it is the client's responsibility to contact their insurance company to resolve. It is the policy of TMS Services of Vancouver that TMS Services of Vancouver collects any

amounts as verified through the client's insurance company, such as co-pays or deductibles. TMS Services of Vancouver will not make multiple verifications if the client disagrees with the information obtained from the insurance company. It is the client's responsibility to contact their insurance company if there are any discrepancies.

If there are billing issues, please contact clinic billing department at 360-831-2276

For self-paying clients who are filing their own claims with insurance companies with which TMS Services of Vancouver is not affiliated, the client will be issued a copy of the encounter form that specifies all criteria needed for insurance companies to process the claim for their member and a receipt of payment.

TMS Services of Vancouver is accepting self-pay clients. All payments for services are due and payable prior to services being rendered.

HEALTH CARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our clinic to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

REQUIRED BY-LAW: We may use or disclose your protected health information 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. You will be notified, if required by law, of any such uses or disclosures.

PUBLIC HEALTH: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

COMMUNICABLE DISEASES: We may disclose your protected health information, 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 protected health information 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, other government regulatory programs and civil rights laws.

ABUSE OR NEGLECT: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information 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 protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

LEGAL PROCEEDINGS: We may disclose protected health information 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), or in certain conditions in response to a subpoena, discovery request or other lawful process.

LAW ENFORCEMENT: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

CRIMINAL ACTIVITY: Consistent with applicable federal and state laws, we may disclose your protected health information, 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. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY ACTIVITY AND NATIONAL SECURITY: When the appropriate conditions apply, we may use or disclose protected health information of