CONSENT & ACKNOWLEDGEMENT

Client Name:_____ Date of Birth:_____

Read each section and ask questions to make informed decisions before signing consent at the end of this document.

1. General & Program Consent

This document is used to acknowledge my participation in the intake and assessment process. I understand that this consent allows ViaQuest Psychiatric & Behavioral Solutions ("PBS") to begin services after appropriate clinical assessment that will recommend specific clinical services to be provided.

---

2. PBS Services

I acknowledge that PBS provides behavioral health and substance use services, which may include, depending on clinical assessment/evaluation and medical necessity:

- Mental and behavioral health assessment including diagnosing
- Individual, family and group psychotherapy services
- Individual, family and group therapeutic behavioral support, case management, care coordination
- Psychiatric evaluation including diagnosing
- Ongoing medication management
- Behavioral Health Integration
- Substance Use Disorder (SUD) services, including Medication-Assisted Treatment (MAT), when clinically indicated
- Crisis intervention Services
- Services delivered in-person and/or via telehealth, where appropriate

I understand that my psychiatric evaluations, assessments, progress notes, treatment plans, medication management records, and other relevant clinical information may be shared among members of my interdisciplinary care team for purposes of treatment coordination, continuity of care, quality improvement, and regulatory compliance. Such information is considered part of my medical record and may be used or disclosed as permitted by HIPAA (e.g. imminent risk of harm to self/others, suspected abuse/neglect, medical emergencies, court order/legal exceptions), State and Federal Regulations. If receiving SUD or MAT services I understand that that my treatment information is protect by 42 CFR Part 2 and cannot be disclosed without my written consent, except when permitted by law (E.g. medical emergencies, mandated reporting).

---

3. Risks & Benefits

I understand the benefit of receiving services could include reduced symptoms, improved coping skills, better functioning, relationships and stability and support during crisis. I understand the risks of receiving services could include temporary emotional discomfort when discussing difficult issues, potential changes in relationships and treatment may not always product improvement. If applicable, I understand the benefits may include reduced cravings, improved stability and decreased risk of relapses or overdose. I understand the risks may include side effects from medications, the need for monitoring, and the possibility that MAT may not work.

---

4. Financial Responsibility & Insurance Authorization

Assignment of Benefits: In consideration of services rendered or to be rendered, I assign to VPBS any benefits due from applicable insurance policies and/or responsible third-party payors, and I authorize payment directly to ViaQuest.

Financial Responsibility: I am financially responsible for amounts not covered by my plan (e.g., copays, coinsurance, deductibles, and non-covered services). Payment is expected at the time of service unless other arrangements are made.

Good Faith Estimate (GFE): If you are uninsured or choose to self-pay, you are entitled to a Good Faith Estimate (GFE) of expected charges. If you schedule at least 10 business days in advance, PBS will provide a written GFE within 3 business days of scheduling. If you schedule at least 3 business days in advance, PBS will provide a written GFE within 1 business day. You may also request a GFE any time before scheduling; PBS will provide it within 3 business days of your request. Keep a copy of your GFE. If your bill is at least $400 more than the GFE, you may dispute the bill through the Patient-Provider Dispute Resolution process. For information, visit the CMS No Surprises site or call 1-800-985-3059.

Sliding Fee Discount Program: A Sliding Fee Discount Program may be available for eligible patients with financial hardship based on household size and income. Discounts apply to medically necessary outpatient services and do not override payer prohibitions on discounting copays/coinsurance. Approval lasts up to 12 months; reapplication is required thereafter.

Financial Assistance and Sliding Fee discounts, including eligibility criteria and timelines, are governed by the VPBS Financial Assistance Policy and Sliding Fee Schedule.

---

5. Acknowledgment of Handbook & Notice of Privacy Practices (NPP)

I acknowledge that I have received or was offered a copy of the Client Handbook, which includes: (a) an explanation of programs and services that may be provided; (b) the Non-Discrimination Notice (c) my client rights (d) Language Access for Limited English Proficiency (LEP) Notice (e) Expectations of Clients (f) Complaint & Conflict Resolution process; and (f) The Company's Notice of Privacy Practices (NPP). I understand the NPP explains how my protected health information (PHI) may be used and disclosed by The Company and my rights regarding my PHI.

I understand that using the Complaint & Conflict Resolution process will not affect the services I receive. I understand that I may request a paper or electronic copy at anytime and can access on the website at any time.

---

6. Communication

I understand that VPBS may communicate with me with non-confidential information for scheduling purposes only via unencrypted email or phone (call/text). For confidential information VPBS may contact me via phone (call only), US Mail and encrypted email.

---

7. Telehealth

I understand that I am being offered behavioral health services through secure telehealth methods allowed by state law and that telehealth visits meet the same standard of care as in-person visits. I also understand that my information is protected by HIPAA and applicable privacy laws, I have had the opportunity to ask questions, and I understand the risks, benefits, and alternatives to telehealth services.

If appliable, I understand that if I am receiving substance use disorder (SUD) treatment, which may include Medication Assisted Treatment (MAT) via telehealth, there may be medications such as buprenorphine or naltrexone prescribed, in accordance with all federal and state laws and current DEA prescribing flexibilities. I understand and agree that telehealth MAT prescribing follows applicable regulations, that I may stop MAT services at any time unless it is medically unsafe to do so abruptly, and that upon starting telehealth services my clinician will complete a Crisis & Emergency Contact Sheet with emergency resources in session.

I understand and agree with the following:

- My location and identity will be verified at the start of each telehealth session.
- I am responsible for choosing a private, safe, and interruption-free location for sessions.
- No telehealth session may be recorded without my consent.
- Technological issues (e.g., disconnection, poor quality) may require rescheduling.
- In the event of an emergency, I agree to call 911 or go to the nearest emergency facility.
- I may request in-person services when clinically appropriate.

I may revoke this authorization at any time by providing written notice to VPBS; and understand it is my right to receive services in person moving forward.

---

8. AI Session Assistance

I authorized VPBS to utilize an artificial intelligence (AI) assisted note-taking tool that helps generate clinical documentation based on information shared during your session(s). The purpose of using AI is to support accuracy and efficiency in administrative tasks so clinicians can focus more on direct engagement with you during your session. A temporary audio recording of the session may be created solely for the purpose of generating a clinical note through a secure AI-assisted transcription and summarization platform. The clinician will review all AI-generated content to reduce potential biases, assumptions, or inaccuracies and will make any necessary edits to ensure the documentation is accurate, complete, and clinically appropriate. Once the clinical documentation has been finalized, the audio recording and any temporary transcription files are permanently deleted. VPBS prioritizes the privacy and confidentiality of your Protected Health Information (PHI). The AI platform encrypts all session information and is used solely for clinical service purposes. The platform complies with applicable security and privacy standards and operates under a contractual agreement with VPBS that includes all required safeguards for PHI. Your information remains protected under applicable federal and state data privacy regulations. Your participation is completely voluntary and is not a condition for receiving services. You may withdraw or revoke your consent at any time without impacting your care.

---

9. Photo, Video & Recording Authorization

I authorize VPBS to film, photograph, or record me; I understand and agree for filming, photograph(s) or recording maybe used for identification, treatment, education & training, and promotion/marketing. I understand and agree that this material may be used within ViaQuest social media, print marketing or website, newspapers, television, magazines, radio, professional journals or discussion groups. No diagnosis or treatment details will be disclosed through these materials. Authorization is voluntary and is not a condition of receiving services. If receiving SUD/MAT services, the information disclosed under this consent may not be released by the recipient unless permitted by 42 CFR Part 2. I may revoke this authorization at any time by providing written notice to VPBS; revocation will not affect uses or disclosures already made in reliance on this authorization.

10.Acknowledgement & Signature

By signing below, I acknowledge and consent to items described above. I understand that I may revoke consent and stop any services at any time.

Client Signature: _____ Date: _____

Legal Representative Name (if applicable): _____ Relationship: _____

Legal Representative Signature: _____ Date: _____

*Legal Representative can include parent, legal guardian, power of attorney.

Witness Representative (if applicable)

Verbal Consent was obtained by witness from legal representatives on Date: _____

Witness Name /Title: _____

Signature: _____ Date: _____

**Controlled Medication Agreement, and Release of Information will be completed in session if applicable.*