Child/Adolescent Client Information and Consent

Welcome and thank you for considering Lifespan Mental Health PLLC ("Lifespan Mental Health PLLC", "us", "Company") for your medical needs. This document contains important information about our professional services and business policies.

Licensed Medical Professional

The medical professional is engaged in private practice providing medical care services to clients on behalf of the Company and not personally. In addition, all staff of the Company are providing services in their capacity under the Company and not personally.

Appointments

Appointments are made by calling 763-200-1160 during the normal business hours listed at www.lifespanmh.com Please call to cancel or reschedule at least 24 hours in advance, or you may be charged for the missed appointment. Third-party payments will not usually cover or reimburse for missed appointments. If you are late, you will be charged for the full amount of the appointment if your insurance coverage allows, and there will be no pro-rating of the fee. If the Medical Professional has to cancel the appointment, you will be entitled to a refund. You shall be discharged from services after three (3) no-shows for appointments automatically. Lifespan Mental Health strives to provide quality care and we are excited to offer a hybrid model where patients can be seen in the office or via telehealth. All new patients must have new patient paperwork completed prior to their initial office visit. Lifespan Mental Health uses Valant for the electronic health record and all patients can use the patient portal called MYIO to complete the required paperwork or any new documents that need to be signed. The portal allows for patients to do several tasks including, but not limited to, updating demographic information, updating insurance information, complete forms, send secure messages, and connect for any telehealth office visits. If new patient forms aren't received prior to 24 hours of the scheduled appointment time, your appointment will be canceled and it is the patient's responsibility to contact the clinic to reschedule. If there are any issues with completing the patient forms prior to the initial office visit, please let us know and we can arrange for you to come into the office for assistance or we will contact you to help trouble-shoot the issues to the best of our abilities.

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the Medical Professional. Your initial session will involve an evaluation of your needs and depending on your circumstances further evaluative sessions may be required. At the end of the evaluation process the undersigned Medical Professional will be able to provide you with some first impressions of what practice may include and a treatment plan to follow if both you and the Medical

Professional agree to work together in your services. You should evaluate this information along with your own opinions of whether you feel comfortable working with the Medical Professional. If you have questions about procedures feel free to discuss them with the Medical Professional at any time. If you have doubts your Medical Professional will be happy to help you set up a meeting with another medical professional for a second opinion.

Crisis or Emergency

If you have a medical emergency - contact 911 and/or visit your nearest emergency room. If you have an active suicidal plan and/or concerns about self-harm or safety, follow your harm reduction plan, if one exists, and then contact 911 and/or visit your nearest emergency room.

Length of Visits

The initial intake and evaluative session is normally scheduled for one (1) hour or one hour and a half (90 minutes) and may run longer depending on the testing or assessments a client is asked to complete. Further evaluative sessions may be scheduled as needed for the Medical Professional to accurately assess your needs. Once the evaluation process is completed medical sessions are generally 30 to 45 minutes in length depending on the circumstances. Total length of visit shall include chart review done during and after the visit, and may not be the total actual face-to-face contact time. An adult must be present at all times for a minor's visit; drop offs are not allowed.

Cancellations

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you may be removed as a patient. You are responsible for calling to cancel or reschedule your appointment. If you miss three (3) appointments, the Company may discharge you as a patient at the Company's discretion.

Payment for Services

You are solely responsible for payment of services. Here are the current rates below:

99204 New Pt Moderate Complexity (45 min): $250.00

99205 New Pt High Complexity (60 min): $350.00

99213 Est Pt Low Complexity (20 min): $150.00

99214 Est Pt Moderate Complexity (30 min): $180.00

99215 Est Pt High Complexity (40 min): $280.00

90833 Psychotherapy w/ E&M Service (30 min): $100.00

90836 Psychotherapy w/ E&M Service (45 min): $150.00

90838 Psychotherapy w/ E&M Service (60 min): $200.00

90785 + Interactive Complexity: $30.00

99417 + Prolonged Services, each 15 minutes: $50.00

99441 Telephone Call--Brief: $50.00

99442 Telephone Call--Intermediate: $75.00

99443 Telephone Call--Lengthy, Complex: $100.00

FAIL Missed Appointment: Cost of the scheduled appointment

LATE Late Cancellation: Cost of the scheduled appointment

These fees are subject to change upon thirty (30) days' prior notice to you. If you are unable to pay, or are not willing to pay, the higher fee after receipt of notice, services may be terminated and you may be given referrals to other competent providers. The undersigned Medical Professional will look to you for full payment of your account, and you will be responsible for payment of all charges. Different copayments are required by various group coverage plans. Your copayment is based on the Medical Policy selected by your employer or purchased by you. In addition, the co-pay may be different for the first visit than for subsequent visits. You are responsible for and shall pay your copay portion of the undersigned Medical Professional's charges for services at the time the services are provided, unless there is applicable insurance coverage in force. It is recommended that you determine your copayment before your first visit by calling your benefits office or insurance company.

Although it is the goal of the undersigned Medical Professional to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event disclosure of your records or the Medical Professional's testimony are requested by you or required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by the Medical Professional at the time of the request or service of the subpoena (current rate is $450/hour) for the time involved in traveling to and from the testimony location, reviewing records and preparing to testify, waiting at the location, and giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the Medical Professional. The Medical Professional may require a deposit for anticipated court appearances and preparation. You will not be entitled to a pro-rated refund.

Mandated Reporting

Under certain state law, persons in designated professional occupations are mandated to report suspected child abuse or neglect or maltreatment of vulnerable adults. Persons who work with

children and families are in a position to help protect children from harm. These persons may be required by law to report, if they know or have a reason to believe that a child or vulnerable adult is being abused or neglected. As a mandated reporter, the mental health professional may be required to break confidentiality and report certain information to the appropriate authorities.

Risks of Services

There are no guarantees in services and the Medical Professional does not make any guarantees with this agreement. You assume the risk of services by signing this form. The Medical Professional is not liable for any adverse reactions to services. The Medical Professional may take any reasonable action necessary during services when there is a dangerous circumstance, as determined by the Medical Professional. You agree to mitigate this risk by disclosing any and all relevant medical information to the Medical Professional

After-Hours Emergencies

Please know that your Medical Professional and Lifespan Mental Health PLLC do not provide twenty-four (24) hour crisis or emergency services. Should you experience an emergency necessitating immediate medical attention, immediately call 911 or if you are able to safely transport yourself, go to the nearest hospital emergency room for assistance.

The COPE mobile crisis teams can come to where you are. The teams respond to anyone in the county who is having a mental health crisis and needs an urgent response. If the situation is life-threatening or you need immediate response call 911.

COPE Hennepin County: Adults 18 and over Call 612-596-1223.

COPE Hennepin County: Children 17 and under, call 612-348-2233.

For other area Mental Health Crisis Response resources are below for your use as appropriate.

Wright/Sherburne/Stearns/Benton County - 1-800-635-8008

Anoka: 763-755-3801, Carver/Scott: 952-442-7601

Dakota: 952-891-7171, Washington: 651-777-5222

Ramsey: adults - 651-266-7900, Olmsted: 1-844-274-7472

The Minnesota Warmline provides a peer-to-peer approach to mental health recovery, support and wellness. Calls are answered by our team of professionally trained Certified Peer Specialists, who have first hand experience living with a mental health condition.The Warmline provides a

safe, anonymous and confidential environment to connect with people who are here to listen. Open Monday-Saturday, 12 PM to 10 PM Call: 651.288.0400 Toll Free 877.404.3190 or text "Support" to 85511

Lifeline Network: If you're thinking about suicide, are worried about a friend or loved one, or would like emotional support, the Lifeline network is available 24/7 across the United States. 24/7 Call: 1-800-273-8255

Poison Control: 800-222-1222. 24 hour hotline for help with medication questions such as questions about accidental overdose, drug interactions or medication side effects.

Contacting Your Medical Professional

Your Medical Professional is not immediately available by telephone unless you have a scheduled telephone visit.. This phone number is not a crisis line or for urgent or emergency medical care. The office number 763-200-1160 is answered by voicemail that the administrative staff will monitor from time to time throughout the day. Although the Medical Professional is typically in the office during normal business hours s/he will not take calls when with a client. There is no guarantee on response times and the best time for communication at the next scheduled appointment. The administrative staff shall attempt to return a call within 72 hours. Depending on the complexity of your questions, you may be asked to schedule an office visit if deemed appropriate by The Medical Professional.

E-Mail and Text Messages

The undersigned Medical Professional and Lifespan Mental Health PLLC does not use and respond to email and text messages to respond to medical concerns. Texts and emails related to your treatment or services as electronic communications are not completely secure and confidential. Any service related questions or issues will not be addressed by the Medical Professional in any electronic communication but will be dealt with during your next session. Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any e-mails, and specifically the website, are not secure and you assume the risks of the insecure transmission.

Social Media

Your Medical Professional does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the Medical Professional and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a

client to surreptitiously gain access to the Medical Professional's personal site(s) will be cause for termination of the services.

Medical Professional's Incapacity or Death

You acknowledge that, in the event the undersigned Medical Professional becomes incapacitated or dies, it will become necessary for another Medical Professional to take possession of your file and records. By signing this information and consent form below, you give consent to allowing another licensed medical professional selected by the undersigned Medical Professional to take possession of your file and records and provide you with copies upon request, or to deliver them to a Medical Professional of your choice. The undersigned Medical Professional will select a successor Medical Professional within a reasonable time and will notify the appointed licensed medical professional.

Audio and Video Recordings

You acknowledge and, by signing this information and consent form below, agree that neither you nor the undersigned Medical Professional will record any part of your sessions unless you and the Medical Professional mutually agree in writing that the session may be recorded. You further acknowledge that the undersigned Medical Professional objects to you recording any portion of your sessions without the Medical Professional's written consent. You expressly agree that audio and video recordings used for security or training purposes are not part of services, and are therefore not protected by confidentiality or any other provisions under this agreement.

Boundaries

It is important for the Company to set clear boundaries with you. The Company works with individuals who may have behavioral situations that make it difficult for the Company to provide effective services. In addition, some individuals may have limited capacity to appreciate and understand the specific services and properly consent without additional individuals present or involved in the process. The Company reserves the right to make treatment decisions in its sole discretion and you agree to hold harmless the Company and its agents for these decisions, regardless of whether they create inconvenience or treatment gaps for you or your child. As a parent or legal guardian, I agree that the Company may set boundaries at its sole discretion. The Company may limit communications, interactions and modify treatment at its sole discretion even if the decisions negatively affect the treatment for a minor.

Legal

This Agreement shall be construed in accordance with, and governed by, the laws of the State of Minnesota as applied to contracts that are executed and performed entirely in Minnesota. The exclusive venue for any court proceeding based on or arising out of this Agreement shall be the county of the medical office address. The parties agree to attempt to resolve any dispute, claim

or controversy arising out of or relating to this Agreement by arbitration, which shall be conducted under the then current arbitration procedures of the American Arbitration Association any other procedure upon which the parties may agree. The parties further agree that their respective good faith participation in arbitration is a condition precedent to pursuing any other available legal or equitable remedy, including litigation, arbitration or other dispute resolution procedures. If any legal action or any arbitration or other proceeding is brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, Lifespan Mental Health PLLC and the Medical Professional shall be entitled to recover legal fees and other costs incurred in that action or proceeding, including lost revenue, in addition to any other relief to which it or they may be entitled. You release Lifespan Mental Health PLLC and the Medical Professional from any good faith refusals of medical records as allowed by law.

Lab work and medical clearance

Lifespan Mental Health may request lab work or further medical evaluation regarding a patient status as part of their care. Some psychiatric medications require urgent or routine lab monitoring for best practices and patient safety. There are some circumstances where psychotropic medications carry other risks for individuals depending on their medical status. Patients will be notified if they are required to have lab work or further medical evaluation prior to any new or on-going prescription refills as directed. Lifespan Mental Health does not offer laboratory services and patients will be provided a lab slip to bring to the lab of their choice. The lab work or additional care may or may not be covered by your insurance and patients are expected to check with their insurance company regarding coverage. Lifespan Mental Health may direct you to fill out a release(s) of information to receive outside records that attests to your medical condition and stability. You will be notified if your healthcare provider requires the information as a means to pursue potential treatment recommendations to assure your safety.

I have read the above information regarding lab work and medical clearance.

Transfer of care:

Lifespan Mental Health may recommend a transfer of your care if deemed necessary and appropriate for your treatment or if you request a transfer as a patient. Patients will be given a written notice of the request to transfer and it will include the following: The reason for the transfer of care, refills for currently prescribed medications, coordination of getting records transferred, and appropriate referrals to outside facilities.

Consent to Treatment

I, voluntarily, agree to receive (or agree for my child to receive) Medical assessment, care, treatment, or services, and authorize Lifespan Mental Health PLLC to provide such care, treatment, or services. I understand that I am not guaranteed a positive outcome. I agree to follow

the agreed upon treatment plan and to inform Lifespan Mental Health PLLC if I alter my treatment plan, experience side effects, or cease to follow my treatment plan..

I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) through Lifespan Mental Health PLLCat any time.

By signing this Client Information and Consent form, I, the undersigned client (or parent/guardian), acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I acknowledge that I received a copy of this signed information and consent form from my Medical Professional.

Client/Parent/Guardian 1 Signature: _____
Date: _____

Parent/Guardian 2 Signature: _____

Date: _____

(If client is a minor and parents are separated)

MINORS ONLY next 2 pages
==========

Minor Treatment Form - <u>Consenting on their Own</u>
Individuals under the age of 18 cannot be treated for health related services without consent. Exceptions to this are governed by Minnesota Statutes, Chapter 144. Exceptions are summarized below and all other treatment requires parental / guardian consent. In signing below I give the Company permission to treat my son/daughter. I may revoke this consent at any time with written notice to the Company.

Conditions When Parental Consent Is Not Needed For Treatment of Minors:

144.341 Living apart from parents and managing financial affairs, consent for self.
Notwithstanding any other provision of law, any minor who is living separate and apart from parent(s) or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing personal financial affairs, regardless of the source or extent of the minor's income, may give effective consent to personal medical, dental, mental and other health services, and the consent of no other person is required.

144.342 Marriage or giving birth, consent for health service for self or child.
Any minor who has been married or has borne a child may give effective consent to personal medical, mental, dental and other health services, or to services for the minor's child, and the consent of no other person is required.

144.343 Pregnancy, venereal disease, alcohol or drug abuse, abortion.
Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

144.344 Emergency treatment.
Medical, dental, mental and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment. 144.3441 Hepatitis B vaccination. A minor may give effective consent for a hepatitis B vaccination. The consent of no other person is required.

144.345 Representations to persons rendering service.
The consent of a minor who claims to be able to give effective consent for the purpose of receiving medical, dental, mental or other health services but who may not in fact do so, shall be deemed effective without the consent of the minor's parent or legal guardian, if the person rendering the service relied in good faith upon the representations of the minor.

144.346 Information to parents.
The professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in the judgment of the professional, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

144.347 Financial responsibility.
A minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services.
==========

Minor Treatment Form - <u>Consenting with Legal Guardian/Parent</u>

Parental / Legal Guardian Consent:

I give Company permission to treat:

_____ _____
Full Name of Minor Child Date of Birth

My signature indicates that I am the legal parent or guardian of the above named minor and that I am allowing my child to be treated at the Company in the event of an accident, injury, illness, or other medical condition. I understand that I am responsible for all costs incurred and that an insurance ready bill will be provided for me to submit to my insurance company. I recognize that I have the right to revoke this consent and that this consent is not needed when the above named individual reaches the age of 18 or meets any of the conditions identified above.

Client/Parent/Guardian 1 Signature: _____
Date: _____

Parent/Guardian 2 Signature: _____
Date: _____
(If client is a minor and parents are separated)

CONTROLLED SUBSTANCES AGREEMENT

I, a patient of the Provider, understands that the Provider may utilize controlled substances (schedule II - V) as part of my treatment. In addition, my Medical Professional has the sole discretion to determine whether or not to prescribe any medication that may be addictive.

I understand I will not have my medications replaced if they are lost or stolen.

For an after hours emergency, including withdrawal symptoms, overdose or loss of medications, I will go to the emergency room. I understand my Provider is not available outside of regular business hours.

I understand my Provider is not available to alter my medication schedule or dosage outside of scheduled appointments.

I will obtain all medication from the same pharmacy and will inform the Provider of the name of that pharmacy.

I will inform the Provider if I have been prescribed any controlled substances by a provider outside of this clinic.

My provider may provide tapering of medications if required, under the sole discretion of the provider.

I understand that a prescription may be given early if the Medical Professional or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.

If the responsible legal authorities have questions concerning my treatment, as may occur, for example, if I obtained medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my full records of controlled substances administration.

I understand that I may be asked to bring my medications in their original container to the Provider clinic while I am on any controlled medication.

I understand that failure to adhere to these policies and/or failure to comply with Medical Professional's treatment plan may result in cessation of therapy with controlled substance prescribing by this Medical Professional or referral for further specialty assessment, as well as possible discharge from the practice.

I, the undersigned patient, attest that the foregoing was discussed with me, and that I have read, fully understand, and agree to all of the above requirements.

_____	_____
Provider signature	Patient signature
_____	_____
Provider name	Patient name
_____	_____
Date	Date