HEALTHCARE AGREEMENT

Client Name (*print)*: _____ Client ID: _____ Client DOB: _____

Thank you for choosing Rosecrance and its affiliates for your behavioral health care.

This Healthcare Agreement ("Agreement") explains the relationship between you and Rosecrance regarding your healthcare, including expectations for our relationship, our obligations, and your obligations. Your signature on this Agreement expresses your consent and agreement to each provision stated in this document.

EXCEPT IN CASES OF EMERGENCY, **YOU MUST SIGN THIS FORM PRIOR TO TREATMENT**.

The Healthcare Agreement contains the following sections:

(1) Your consent to be treated by Rosecrance;

(2) How to access information about your rights and responsibilities;

(3) Your authorization to release your protected health information for care coordination and payment purposes; and

(4) A financial agreement guaranteeing your payment for services.

CONSENT FOR TREATMENT

General Consent: Signing this Agreement indicates your consent to care and treatment by Rosecrance, its affiliates, its employees, agents, and its contracted healthcare providers who are authorized by Rosecrance to provide treatment and care to you ("Rosecrance Providers"). You give your voluntary consent to treatment at Rosecrance and recognize that the success of your treatment rests in your willingness to cooperate in the voluntary treatment process.

Treatment by Independent Contractors: You understand that many health care professionals who will be a part of your Rosecrance care team ***are NOT employees, agents, or apparent agents of Rosecrance or its affiliates***. You understand that you will have no vicarious cause of action against Rosecrance for the malpractice of those non-employee, non-agent professionals.

Treatment by Students, Interns, and Other Trainees: Your care team at Rosecrance may include resident physicians, students, interns, or other trainees. You understand and give your consent to treatment and care from the resident physicians, students, interns, and other trainees. Alternative arrangements for a different care provider can be made upon request.

Third Party Medical Services: Rosecrance may recommend that you receive additional healthcare services from outside providers, such as lab testing, pharmacy services, dental care, and emergency medical treatment as deemed appropriate and necessary by Rosecrance. You authorize Rosecrance to refer you to appropriate third party providers. Alternative arrangements may be made upon request. You will receive separate bills from any third parties providing such services. You understand that you will be responsible for any costs charged by third parties when receiving these services.

Telehealth Services: You consent to receive treatment and services through telehealth, including through interactive video or audio platforms, whether these platforms are HIPAA-compliant or not. You consent to the inherent risks to your protected health information associated with telehealth services, including unsecure or unencrypted transmission; audio or video interruptions; access by unauthorized persons; or unexpected disruptions from technical failures. Although it is unlikely, you understand that your protected health information may be disclosed if the technology fails or if it is breached.

Waiver and Limitation of Liability: TO THE FULLEST EXTENT PERMITTED BY LAW, IN NO EVENT SHALL ROSECRANCE BE LIABLE FOR ANY INDIRECT, INCIDENTAL, PUNITIVE, CONSEQUENTIAL, EXEMPLARY, SPECIAL, OR CONSEQUENTIAL DAMAGES ARISING FROM OR RELATED TO YOUR RECEIPT OF ROSECRNCE CARE OR SERVICES. ROSECRANCE'S TOTAL LIABILITY FOR ANY CLAIM WILL BE THE ACTUAL DAMAGES INCURRED BY YOU, NOT EXCEED THE TOTAL AMOUNT PAID BY YOU TO ROSECRANCE FOR SERVICES IN THE TWELVE (12) MONTHS PRECEDING THE EVENT. THIS LIMITATION DOES NOT APPLY TO CLAIMS RESULTING FROM ROSECRANCE'S GROSS NEGLIGENCE, WILLFUL MISCONDUCT, OR WHERE OTHERWISE PROHIBITED BY LAW.

As part of your treatment, you may have the opportunity to engage in optional recreational or fitness activities that involve the inherent risk of injury. On behalf of yourself and all your heirs, assigns, or representatives, you hereby waive, release, and forever discharge Rosecrance from all liabilities that might arise from your participation in these activities.

Additionally, Rosecrance is not liable or responsible for any personal property that is damaged, lost, stolen, or left behind while on our premises including, but not limited to, a vehicle or its contents.

Any claim related to care, services, or activities provided by Rosecrance must be brought within one (1) year of the date the alleged issue occurred.

Electronic Communication and Video Surveillance: You consent to electronic communications from Rosecrance including emails, voicemails, and text messages. You acknowledge and accept the inherent risks in the electronic transmission of unencrypted information, including that such communications may be lost, delayed, intercepted, corrupted, or otherwise not delivered. You understand that Rosecrance facilities may employ video surveillance equipment for security monitoring purposes, and you further understand that it is possible that your image will be captured by that equipment and that such images are protected by state and federal confidentiality laws.

Use of Artificial Intelligence Software: You consent to Rosecrance's use of artificial intelligence software to facilitate clinical notetaking and documentation. This software generates automated notes from your patient encounters ("session") based on audio of your session with a Rosecrance provider. All documentation generated by this software is reviewed, corrected, and approved by your Rosecrance provider to ensure the accuracy and completeness of your medical record. The audio of your Rosecrance sessions is not recorded or stored in any way. If you do not consent, alternative arrangements can be made upon request.

NOTICE OF YOUR RIGHTS AND ROSECRANCE'S POLICIES

By law, Rosecrance is required to provide you with certain information and notices. For your convenience, these notices are available in multiple locations and in multiple formats. You may access patient notices in the following locations and ways:

- in the Client Treatment Guide;
- on our website at Rosecrance.org;
- in the Rosecrance myHealthPointe Consumer Portal; or
- by requesting a printed copy at any Rosecrance location.

The information contained in these legal notices include information about the following topics:

- **Notice of Privacy Practices**
- **Client Rights and Responsibilities**

For certain programs and services, the following policies also apply and are available to you:

- **Restraint and Seclusion Policy Regarding Residential Clients Under the Age of 21**
- **Declaration of Mental Health Treatment Policy for Adult Clients**
- **Advanced Directives Policy for Residential Adults Clients with Advance Directives**
    - Please be advised that, though Rosecrance will comply with your Advance Directives as legally required, we are unwilling to comply with advance directives that explicitly decline CPR or other life-saving measures. The decision to administer life-saving measures in our facilities will be based on the medical judgment of our healthcare professionals, taking into consideration the specific circumstances and best interests of the client.

Your signature at the end of this form indicates that you have had the opportunity to review the documents listed above; that you have had the opportunity to ask questions about the content of the notices and policies provided; and that you have received, read, and understood the content of the notices and policies listed above.

AUTHORIZATION TO RELEASE INFORMATION

Authorization: You authorize Rosecrance and its affiliates ("Rosecrance") to disclose and receive protected health information for the purpose of treatment, payment, and health care operations from your treating providers, health plans, third-party payers, and people helping to operate this program. This authorization is consistent with the information you received in the Notice of Privacy Practices.

Recipients: You authorize Rosecrance to disclose and receive information from your treating providers, health plans, third-party payers, and people helping to operate this program. This includes exchanging information between and among Rosecrance entities and affiliates.

Information to be Disclosed: You authorize Rosecrance to disclose and receive the following information:

- your presence in treatment;
- your demographic information;
- your treatment information including assessment, diagnosis, treatment plan, dates of service, type of service and level of care received;
- financial information; and
- any other information that is necessary to obtain authorization for services, to determine eligibility, to coordinate benefits, to submit health care claims, and to obtain reimbursement for services.

Purpose: You understand that this Authorization will allow Rosecrance to use your protected health information as allowed under applicable laws for all future uses and disclosures for treatment, payment, and health care operations, for example, getting payment from your insurer or coordinating your care with other providers

Redisclosure: You understand that your health information may be redisclosed in accordance with the permissions contained in the HIPAA Privacy Rule, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you.

Fundraising: You authorize the use or disclosure of your demographic information for the purpose of fundraising for the benefit of The Rosecrance Foundation. You may opt out of any communications from Rosecrance relating to fundraising.

Accounting of Disclosures: You have the right to request a list of disclosures of your protected information made by Rosecrance.

Restrictions: You have the right to request restrictions on disclosures for treatment, payment, and health care operations.

Revocation: You have the right to revoke this authorization, in writing, at any time by sending a written notification to the Rosecrance Medical Records Department, except to the extent that Rosecrance has already acted in reliance on this authorization.

Expiration: This authorization will expire one year from the date on which you sign it, if you remain in treatment at that time, or one year from the date on which you complete treatment.

FINANCIAL AGREEMENT

Rosecrance is committed to providing quality care to our clients and ensuring transparent billing practices. Please review our financial policies below. Your signature on this form indicates your agreement with our financial and billing practices as outlined below.

Guarantee of Payment:

- You agree to be financially responsible for all charges for services provided.

Insurance Billing:

- You agree to provide current and accurate insurance information regarding all active health insurance benefits.
- Rosecrance will verify your benefits prior to starting treatment and will share this information with you, but this does not guarantee payment.
- You are responsible for all charges for services not covered by your insurance or that are required by your insurance plan, such as co-payments ("co-pays") and deductibles. You are also responsible for all charges when insurance has declined coverage.
- All applicable insurance co-pays must be paid in full at the time of service.

Assignment of Benefits:

- In exchange for treatment by Rosecrance, you assign to Rosecrance your rights to receive payment of your authorized insurance benefits, as well as all rights, powers, authority, and standing to pursue amounts owed under your health insurance plan. This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal or administrative claims.
- You authorize Rosecrance to file appeals for any denial of payment or benefit determination.

Self-Pay Option:

- For clients without insurance coverage, we offer a self-pay option for our services **which will be charged to your card on file at the time of service.**

Balance Settlement:

- Your account balance is the amount that your insurance carrier has determined to be your responsibility for your services. **You will receive a statement detailing your responsibility for services received. Your credit or debit card on file will be charged accordingly.**
- We reserve the right to suspend or terminate services for accounts more than 60 days past due.
- If your account balance remains unpaid for more than 90 days, Rosecrance may refer it to a third-party collection agency. Please note that Rosecrance must pay administrative fees when it refers your balance to a collection agency, no matter whether you pay Rosecrance or pay the collection agency following that referral. **In the event that your balance is referred to a collection agency, and you elect to make a payment to Rosecrance instead of the collection agency, you will be responsible for the repayment to Rosecrance of that administrative fee, which is equal to 25% of your payment.**

Missed Visits:

- Missed visits and appointments canceled with less than 24 hours' advance notice will result in a $100.00 fee.
- Missing up to three (3) appointments within a 12-month period could result in dismissal from our services.

Credit/Debit Card Authorization:

- Rosecrance requires clients to provide a credit or debit card to be stored with our HIPAA-compliant, secure electronic payment vendor.
- You authorize Rosecrance to charge the credit or debit card that you provided for co-pays, outstanding balances, and missed visit fees.
- You agree to **immediately** inform Rosecrance of any changes to your credit/debit card information. If the card on file is declined for any reason, **future services will be suspended** until we receive updated payment information.

By signing below, you are indicating that you have read, understood, and agree to the provisions in this Healthcare Agreement. You acknowledge that Rosecrance staff has explained this agreement to you, and that you have been given the opportunity to ask questions and have no remaining questions or concerns at this time.

Client Name (Print)	Client ID #	Client DOB

Client Signature	Date

Name of Parent, Guardian, or Personal Representative (Print)

Parent / Guardian Signature, *if applicable*	Date

Staff / Witness Signature	Date