Client Information

Today's Date
Client Name
Date of Birth
AHCCCS ID
Client's Email Address

Health Current

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Radiology reports
- Medical history
- Clinic and doctor visit information
- Medications
- Health plan enrollment and eligibility
- Allergies
- Lab test results
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law. Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current. The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use. You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may 'opt out' of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider. Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.
2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.
3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

By signing below, I acknowledge that I have read and understand the SAGE Counseling, Inc. Standards of Conduct. Furthermore, I agree to abide by the Standards of Conduct and voluntarily subject myself to any potential consequence of my non-compliance to the Standards of Conduct.

Please sign using your full name

Client's Full Name

Date of Signature

HIE Consent

CONSENT TO RELEASE BEHAVIORAL HEALTH & SUBSTANCE ABUSE INFORMATION

By signing this form, I permit all of my past, present and future healthcare providers where I have received behavioral health treatment, including any treatment for substance use disorders, to release my information to Health Current, the statewide health information exchange (HIE), and to the organization listed here:

I am receiving (or will receive) treatment from this organization. The purpose of this disclosure is for:

1. My treatment;
2. Payment for my treatment (for example, billing insurance companies); and
3. Healthcare operations activities (for example, improving the quality of care for patients, managing the care of patients, patient safety activities, and other activities necessary to run a health care organization).

I authorize the disclosure of all my medical information for these purposes, including behavioral health information and substance use disorder information (e.g., drugs and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health, communicable disease-related information, and HIV/AIDS-related information.

I understand that the organization listed above will obtain this information about me through Health Current, the statewide HIE. I understand that if I previously opted out of having my health information shared through the HIE, this form will change that decision. I understand that if I sign this form, I agree to have my health information shared through the HIE. I understand that I can change this decision at any time.

By signing below, I acknowledge that I have read and understand the SAGE Counseling, Inc. Standards of Conduct. Furthermore, I agree to abide by the Standards of Conduct and voluntarily subject myself to any potential consequence of my non-compliance to the Standards of Conduct.

Please sign using your full name

Client's Full Name

Date of Signature

Client Acknowledgment

I acknowledge that I have had the opportunity to review and/or receive a copy of the following information and resources:

1. Informed Consent
2. Client Rights
3. The complaint procedure for SAGE Counseling, Inc.
4. The contact information for the following state entities:
5. Arizona Department of Health Service, Bureau of Medical Facilities Licensing
6. Arizona Department of Adult Protective Services
7. Arizona Department of Child Safety
8. Human Rights Advocate Office of Human Rights
9. The contact information for the following crisis services
10. Maricopa Crisis Line: 800-631-1314
11. Terros Crisis Team: 602-685-6000
12. Southern Counties Crisis Line: 866-495-6735
13. Northern Counties Crisis Line: 877-756-4090
14. Empact: 800-259-3449
15. 911
16. The contact information and member handbook (electronic or paper format) for the following Health Plans
17. Care1st
18. https://care1staz.com/az/members/handbook.asp
19. Steward Health Choice Arizona
20. https://www.stewardhealthchoiceaz.com/members/member-handbooks
21. Banner University Family Care
22. https://www.bannerufc.com/en/acc/plan-information/plan-materials#Member-Handbook
23. Magellan Complete Care
24. https://www.mccofaz.com/member/member-handbook
25. Mercy Care
26. https://www.mercycareaz.org/members/completecare-formembers/handbook
27. United Healthcare Community Plan
28. https://www.uhccommunityplan.com/az/medicaid/ahcccs.html
29. Arizona Complete Health
30. https://www.azcompletehealth.com/members/medicaid/resources.html
31. Notice of Privacy Practices according to the Health Insurance Portability and Accountability Act (HIPAA).
32. The program information and program guidelines, including Standards of Conduct.
33. SAGE Counseling, Inc. Notification of Supervision
34. For the safety of our staff members and clients, there are security cameras at some of our locations. I acknowledge, by signing this document, that I may be videotaped in common areas for security purposes. SAGE Counseling, Inc. will not share the video for any reason other than for security purposes.
35. Assessments at SAGE Counseling, Inc. are valid for 12 months from the time of the initial assessment. However, if a discharge from services occurs, an intake appointment will be necessary to gather current information. Therefore, by signing this document, I acknowledge I understand the following:
36. *If I am discharged from services within 12 months of my initial assessment and opt to return to treatment, I understand I will need to complete, and possibly provide payment for, an intake assessment to bring my medical record current.*
37. *I also understand that if I am discharged from services and opt to return to the agency after 12 months from my initial assessment, I will be required to complete a new comprehensive assessment and will pay the associated fees for this service, if applicable.*
38. *I also understand that any treatment I have received from SAGE Counseling, Inc. or another provider that has taken place longer than 12 months ago will not be substituted for treatment recommendations made by SAGE Counseling, Inc.*
39. For clients complete DUI Screening services, I understand that I must complete my associated DUI Treatment within 16 weeks or my referring agency's requirement, whichever is the shortest amount of time.

40. I attest that the financial information I have provided is accurate to the best of my knowledge. I understand that if any of the financial information I have provided is discovered to be false, or intended to purposefully mislead SAGE Counseling, Inc. or its payers, I may be responsible for up to 100% of the standard fees for the services provided to me by SAGE Counseling, Inc. I also agree to pay for any required fees for services provided to me.

By signing below, I acknowledge that I have read and understand the SAGE Counseling, Inc. Standards of Conduct. Furthermore, I agree to abide by the Standards of Conduct and voluntarily subject myself to any potential consequence of my non-compliance to the Standards of Conduct.

Please sign using your full name

Client's Full Name

Date of Signature

Standards of Conduct

At SAGE Counseling, Inc. we maintain a high standard of ethical, legal and moral behavior with our clients. In rare instances where a client engages in activities detrimental to another individual, or themselves, SAGE Counseling, Inc. may be required to take appropriate actions to protect the safety and continuity of the Program and its clients. Although SAGE Counseling, Inc. is highly motivated to provide ample opportunity for successful and positive treatment activities, there are instances that may require SAGE Counseling, Inc. to suspend or terminate treatment services involuntarily.

A client may be suspended or involuntarily discharged from SAGE Counseling, Inc. for any of the following reasons:

- Failure to adhere to established attendance policy.
- Non-payment of appropriate fees. A client receiving services paid for via AHCCCS is exempt from being discharged from services due to financial reasons.
- Lack of participation in treatment process, which could include but is not limited to failure to complete assignments, repeated tardiness, failure to participate in group discussions, sleeping during group, etc.
- History of highly disruptive behavior with SAGE Counseling, Inc. staff members or its clients.
- Attending treatment services under the influence of alcohol or other drugs.
- Lack of compliance with program rules including Group Guidelines.
- Use of cell phone or other recording device during clinical services.
- Violating a clients right to confidentiality.
- Engaging in aggressive, hostile or threatening behavior during the treatment process.

A client may be suspended or involuntarily discharged from SAGE Counseling, Inc. Domestic Violence Treatment Program for any of the following reasons:

- Documented evidence of harassment or abuse of the offenders victim or any other individual after admission into the Domestic Violence Treatment Program.
- Documented evidence of attempt to influence or control a victims contact or involvement with SAGE Counseling, Inc., another agency, or criminal justice entity.
- Documented evidence of the commission of a new domestic violence related offense, including the violation of an Order of Protection or Injunction of Harassment.

Disciplinary Actions

If any of the above behaviors occur while receiving treatment services at SAGE Counseling, Inc., consequences may be imposed in efforts to continue treatment services, when possible. Depending upon the intensity, frequency and severity of the inappropriate behaviors by the client, SAGE Counseling, Inc. may impose any of the following actions:

- A verbal warning may be issued to the client by any SAGE Counseling, Inc. staff member and documented in the medical record.
- The referral source referring the client to treatment may be notified, which may lead to early discharge from treatment services.
- A client may be required to meet with a member of the SAGE Counseling, Inc. Clinical Leadership Team prior to further participation in treatment services.
- A client may be recommended for additional and/or alternative treatment services, such as increased amount, increased intensity and/or a change in the type of treatment services delivered to the client.
- A client may be required to complete treatment services at a different SAGE Counseling, Inc. location.
- Other actions deemed appropriate and necessary by the SAGE Counseling, Inc. Clinical Leadership Team.

Attendance Guidelines

In order to get the most from your treatment, and to comply with contractual requirements, regular attendance is necessary to your assigned group(s); therefore, SAGE Counseling, Inc. maintains strict attendance standards. This means that you are required to attend all assigned group sessions and/or education classes in order to complete your program. Supporting documentation may be requested for any absences, and prior contact or at least within 24 hours after the absence, to your Program Assistant is required. Exceptions to this standard may be granted on a case-by-case basis, by your assigned Program Assistant, in the event of unforeseen circumstances.

This means you are required to arrive on time and attend all assigned clinical services in order to complete your program successfully. Late arrivals will not be allowed to enter the group.

Appropriate Dress Guidelines

SAGE Counseling strives to maintain a safe, therapeutic environment for all employees and clients. Attire that is determined to be provocative, offensive, or revealing is prohibited. Inappropriate dress may result in you being dismissed from clinical services.

By signing below, I acknowledge that I have read and understand the SAGE Counseling, Inc. Standards of Conduct. Furthermore, I agree to abide by the Standards of Conduct and voluntarily subject myself to any potential consequence of my non-compliance to the Standards of Conduct.

By signing below, I acknowledge that I have read and understand the SAGE Counseling, Inc. Standards of Conduct. Furthermore, I agree to abide by the Standards of Conduct and voluntarily subject myself to any potential consequence of my non-compliance to the Standards of Conduct.

Please sign using your full name

Client's Full Name

Date of Signature

Informed Consent

PARTICIPATION IN TREATMENT:

I VOLUNTARILY CONSENT TO PARTICIPATE IN OUTPATIENT CLINICAL SERVICES WITH SAGE COUNSELING, INC. I UNDERSTAND THAT NO GUARANTEES HAVE BEEN MADE TO ME REGARDING THE RESULTS OF THIS TREATMENT. SUCH PROGRAMS, WHICH ARE SET UP FOR HELPING PEOPLE WITH SUBSTANCE ABUSE PROBLEMS, PARENTING CHALLENGES, COGNITIVE RESTRUCTURING NEEDS, ANGER MANAGEMENT PROBLEMS, GENERAL MENTAL HEALTH OR BEHAVIORAL HEALTH ISSUES, OR PROBLEMS WITH CRIMINAL CONDUCT, HAVE A GREATER CHANCE OF BEING SUCCESSFUL WHEN, I, THE CLIENT AM WILLING TO FULLY PARTICIPATE IN THE PROGRAM. PART OF THE TREATMENT SERVICES OFFERED BY SAGE COUNSELING, INC. INCLUDE A FORMAL DIAGNOSIS, RECOMMENDATIONS FOR CARE, AND A SERVICE PLAN. I UNDERSTAND THAT I HAVE A RIGHT TO PARTICIPATE IN THE CREATION AND/OR MODIFICATION OF MY SERVICE PLAN AND AGREE TO WORK HARMONIOUSLY WITH SAGE COUNSELING, INC. TO ENSURE MY SERVICE PLAN IS ACCURATE THROUGHOUT THE COURSE OF TREATMENT. PARTICIPATION IN COUNSELING AND THERAPY SERVICES ARE BENEFICIAL, BUT AS WITH ANY TREATMENT, THERE ARE INHERENT RISKS. I ACKNOWLEDGE THAT THROUGH THE SERVICES PROVIDED BY SAGE COUNSELING, INC., I MAY HAVE DISCUSSIONS ABOUT PERSONAL ISSUES WHICH MAY BRING TO THE SURFACE FEELINGS SUCH AS SADNESS, ANGER, GUILT, ETC. SOME OF THE POSSIBLE BENEFITS OF TREATMENT INCLUDE IMPROVED PERSONAL RELATIONSHIPS, ENHANCED SELF-EFFICACY, REDUCED FEELINGS OF EMOTIONAL DISTRESS, AND INCREASED PROBLEM SOLVING SKILLS. SAGE COUNSELING, INC. ENCOURAGES ITS CLIENTS TO DISCUSS PROGRESS OR CONCERNS AT ANY TIME WITH MEMBERS OF THE CLIENTS CLINICAL TEAM. I UNDERSTAND THAT I AM OPTING INTO SERVICES VOLUNTARILY, AND THUS, MAY END TREATMENT SERVICES WITH SAGE COUNSELING, INC. AT ANY TIME, FOR ANY REASON. I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO WITHHOLD OR WITHDRAW CONSENT FOR TREATMENT IN WRITING OR ORALLY, AT ANY TIME. IN THE EVENT I TERMINATE TREATMENT SERVICES, I UNDERSTAND THAT THE REFERRING PARTY WHO REFERRED ME TO TREATMENT WILL BE NOTIFIED BY SAGE COUNSELING, INC. AS A PARTICIPATING MEMBER IN COUNSELING PROCESSES, I ACKNOWLEDGE THE RISKS OF THIS SERVICE AND AGREE TO UPHOLD CONFIDENTIALITY OF ALL PARTICIPATING MEMBERS. I UNDERSTAND THAT SAGE COUNSELING, INC. CAN MAKE RECOMMENDATIONS FOR ADDITIONAL TREATMENT AT ANY POINT DURING THE COURSE OF TREATMENT IF THERE APPEARS TO BE A CLINICAL NEED FOR ALTERNATIVE OR ADDITIONAL SERVICES. I UNDERSTAND THAT I RESERVE THE RIGHT TO AGREE OR NOT AGREE WITH THESE RECOMMENDATIONS. IF THE RECOMMENDATIONS MADE ARE NOT ACCEPTED BY ME, SAGE COUNSELING, INC. RESERVES THE RIGHT TO DISCHARGE ME FROM TREATMENT, AND REPORT TO THE REFERRING PARTY OF MY NON-COMPLIANCE. ADDITIONALLY, I ACCEPT ANY CONSEQUENCES INCURRED AS A RESULT OF MY NON-COMPLIANCE. FURTHERMORE, I UNDERSTAND THAT SAGE COUNSELING, INC. RESERVES THE RIGHT TO SUSPEND AND/OR TERMINATE TREATMENT PROVISIONS FOR CLIENT VIOLATION OF THE SAGE COUNSELING, INC. CODE OF CONDUCT.

BY SIGNING THIS INFORMED CONSENT, I ACKNOWLEDGE AND ALLOW SAGE COUNSELING TO COMMUNICATE WITH ME THROUGH EMAIL, SMS TEXT MESSAGING, TELEPHONE AND VOICEMAIL MESSAGING. SAGE COUNSELING SHALL MINIMIZE THE CONTENT OF THESE MESSAGES TO PRESERVE MY PRIVACY. WHILE SAGE COUNSELING DOES NOT CHARGE FOR THIS SERVICE, MY WIRELESS PROVIDER MAY IMPOSE A FEE FOR SENDING AND/OR RECEIVING SMS MESSAGES.

CONFIDENTIALITY AND EXCLUSIONS:

THE INFORMATION GATHERED DURING THE COURSE OF TREATMENT IS CONFIDENTIAL, EXCEPT AS REQUIRED BY STATE AND FEDERAL LAW. IN ORDER TO RELEASE PROTECTED HEALTH INFORMATION TO AN OUTSIDE ENTITY, A CLIENT SHALL COMPLETE AND SIGN A RELEASE OF INFORMATION (ROI). A ROI SHALL EXPIRE ONE-YEAR FROM THE DATE OF INCEPTION, OR MAY TERMINATE EARLY THROUGH A CLIENTS WRITTEN REQUEST. THE PROCESS TO REVOKE AN ROI IS OUTLINED IN THE SAGE COUNSELING, INC. PRIVACY POLICY. THERE ARE SEVERAL EXCEPTIONS TO CONFIDENTIALITY. CLIENTS REFERRED TO SAGE COUNSELING, INC. BY PROBATION, PAROLE, DEPARTMENT OF CHILD SAFETY (DCS), OR A

JUDICIAL BODY, ARE REQUIRED TO GRANT SAGE COUNSELING, INC. PERMISSION TO SHARE INFORMATION WITH THE REFERRING PARTY. PERMISSIONS OF THIS NATURE ARE TYPICALLY OBTAINED BY MEANS OF RELEASE OF INFORMATION SIGNED BY THE CLIENT. SAGE COUNSELING, INC. CAN ALSO SHARE INFORMATION WITH THE REFERRAL SOURCE FOR PURPOSES SUCH AS STATISTICAL ANALYSIS, RESEARCH, BILLING PURPOSES, OR OTHER REASONS AS PERMITTED WITHIN THE HIPAA REGULATIONS AND/OR THE AMERICAN COUNSELING ASSOCIATION CODE OF ETHICS. THERE ARE ALSO SOME INSTANCES IN WHICH A STAFF MEMBER IS ETHICALLY AND/OR LEGALLY REQUIRED TO TAKE ACTION TO PROTECT OTHERS FROM POTENTIAL HARM, EVEN THOUGH THAT REQUIRES REVEALING SOME INFORMATION ABOUT A CLIENTS TREATMENT. IF A SAGE COUNSELING, INC. EMPLOYEE BELIEVES THAT A CHILD, AN ELDERLY PERSON, OR A DISABLED PERSON IS BEING ABUSED OR NEGLECTED, THAT EMPLOYEE MUST FILE A REPORT WITH THE CHILD OR ADULT PROTECTIVE SERVICES. IF A SAGE COUNSELING, INC. EMPLOYEE BELIEVES THAT A CLIENT IS THREATENING SERIOUS BODILY HARM TO ANOTHER, THAT EMPLOYEE MUST TAKE PROTECTIVE ACTION, WHICH MAY INCLUDE NOTIFYING THE POTENTIAL VICTIM, NOTIFYING THE POLICE, AND/OR SEEKING APPROPRIATE HOSPITALIZATION OF THE CLIENT. IF A SAGE COUNSELING, INC. EMPLOYEE BELIEVES THAT A CLIENT MAY BE AT RISK OF HARMING HIM/HERSELF THAT EMPLOYEE MAY BE REQUIRED TO SEEK HOSPITALIZATION FOR THE CLIENT OR CONTACT FAMILY MEMBERS OR OTHERS WHO CAN HELP PROVIDE PROTECTION FOR THE CLIENT. CLIENT MEDICAL RECORDS MAY BE INSPECTED BY MEMBERS OF THE SAGE COUNSELING, INC. CLINICAL TEAM FOR THE FOLLOWING PURPOSES: RECORDING CLINICAL, CASE MANAGEMENT, AND CARE COORDINATION, QUALITY IMPROVEMENT AND COMPLIANCE ACTIVITIES, OR INTERNAL TRAINING OPPORTUNITIES. MEDICAL RECORDS MAY ALSO BE INSPECTED BY OTHER SAGE COUNSELING, INC. PERSONNEL INCLUDING REPRESENTATIVES FROM INFORMATION TECHNOLOGY, QUALITY IMPROVEMENT AND COMPLIANCE AND ADMINISTRATIVE STAFF MEMBERS FOR THE PURPOSES OF ADMINISTRATIVE ACTIVITIES, AUDITING AND REVIEW, AND TECHNICAL ASSISTANCE ACTIVITIES. A LOG OF ALL PERSONNEL THAT ACCESS A CLIENTS MEDICAL RECORD IS MAINTAINED AND AVAILABLE FOR REVIEW.

AS PART OF ARIZONA STATE LICENSING REQUIREMENTS, SAGE COUNSELING, INC. MUST ALSO RELEASE THE REQUIRED INFORMATION THAT PERTAINS TO YOUR CASE TO ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS) UPON REQUEST. MY SIGNATURE BELOW ACKNOWLEDGES SAGE COUNSELING, INCS RESPONSIBILITY TO REPORT SUSPECTED OR CONFIRMED OPIOID RELATED DEATH OR OVERDOSE TO THE ARIZONA DEPARTMENT OF HEALTH SERVICES. SAGE COUNSELING, INC. DOES NOT REQUIRE MY CONSENT FOR THE RELEASE OF CERTAIN CONFIDENTIAL INFORMATION WITHIN THE SCOPE OF TREATMENT, PAYMENT OR OPERATIONS, AS DEFINED BY THE HIPAA. ADDITIONALLY, AND AS REQUIRED BY LAW, I UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION MAY BE RELEASED IN RESPONSE TO A COURT ORDER OR MANDATE FROM A STATE OR FEDERAL ENTITY. MY SIGNATURE BELOW EXPLICITLY PROVIDES THESE PERMISSIONS.

IN THE EVENT OF AN EMERGENCY SITUATION, SAGE COUNSELING WILL ATTEMPT TO CONTACT THE EMERGENCY CONTACT IDENTIFIED BY CLIENT AT THE TIME OF ASSESSMENT. BY SIGNING THIS INFORMED CONSENT, I GRANT SAGE COUNSELING PERMISSION TO CONTACT MY IDENTIFIED EMERGENCY CONTACT IN THE EVENT OF AN EMERGENCY SITUATION.

SAGE COUNSELING, INC. BUSINESS RELATIONSHIPS:

SAGE COUNSELING, INC. HAS MANY BUSINESS RELATIONSHIPS WITH ENTITIES WHO SUPPORT, ENABLE, OR ADVANCE THE BUSINESS OPERATIONS OF THE COMPANY. IN ORDER TO MAINTAIN COMPLIANCE WITH THE HIPAA, SAGE COUNSELING, INC. ENSURES THAT ANY BUSINESS-TO-BUSINESS RELATIONSHIP INVOLVING OR POTENTIALLY INVOLVING ACCESS TO CLIENT MEDICAL INFORMATION INCLUDES A BUSINESS ASSOCIATE AGREEMENT (BAA).

SAGE COUNSELING, INC. HAS PARTNERED WITH HEALTH CURRENT, AN ONLINE PLATFORM DESIGNED FOR THE EXCHANGE OF HEALTH INFORMATION. IN AN EFFORT TO COORDINATE CARE WITH OTHER HEALTHCARE PROVIDERS, SAGE COUNSELING MAY SHARE INFORMATION RELATED TO MY HEALTH CARE AND PARTICIPATION IN TREATMENT SERVICES. OTHER HEALTHCARE PROVIDERS ACCESSING THIS INFORMATION MAY BE CURRENT OR FUTURE PROVIDERS OF MY HEALTHCARE SERVICES.

SAGE COUNSELING, INC HAS PARTNERED WITH ELEOS, A SOFTWARE PROGRAM WITH VOICE ANALYSIS THAT ASSISTS WITH CLINICIAN DOCUMENTATION. I UNDERSTAND THAT INFORMATION GATHERED BY ELEOS MAY BE USED FOR SUPERVISION, DOCUMENTATION, ANALYTICAL, QUALITY, AND TRAINING PURPOSES. THE INFORMATION IS SECURED THROUGH END-TO-END ENCRYPTION AND SECURELY STORED, HIPAA-COMPLIANT SOFTWARE PROGRAM THAT YOUR CLINICIAN MAY USE IN SESSIONS.

I ACKNOWLEDGE THAT I RECEIVED AND READ THE NOTICE OF HEALTH INFORMATION PRACTICES. I UNDERSTAND THAT MY HEALTHCARE PROVIDER PARTICIPATES IN HEALTH CURRENT, ARIZONA'S HEALTH INFORMATION EXCHANGE (HIE). I UNDERSTAND THAT MY HEALTH INFORMATION MAY BE SECURELY SHARED THROUGH THE HIE, UNLESS I COMPLETE AND RETURN AN OPT OUT FORM TO MY HEALTHCARE PROVIDER.

CLIENT RIGHTS:

SAGE COUNSELING, INC. ENSURES THAT:

- A CLIENT IS TREATED WITH DIGNITY, RESPECT, AND CONSIDERATION.
- A CLIENT IS NOT SUBJECTED TO: ABUSE; NEGLECT; EXPLOITATION; COERCION; MANIPULATION; SEXUAL ABUSE; SEXUAL ASSAULT; SECLUSION; RESTRAINT (IF NOT NECESSARY TO PREVENT IMMINENT HARM TO SELF OR OTHERS).
- A CLIENT IS NOT SUBJECTED TO RETALIATION FOR SUBMITTING A COMPLAINT TO THE ARIZONA DEPARTMENT OF HEALTH OR ANOTHER ENTITY.
- A CLIENT MAY REFUSE OR WITHDRAW CONSENT TO TREATMENT BEFORE TREATMENT IS INITIATED.
- EXCEPT IN AN EMERGENCY, A CLIENT IS INFORMED OF ALTERNATIVES TO A PROPOSED PSYCHOTROPIC MEDICATION OR SURGICAL PROCEDURE AND ASSOCIATED RISKS AND POSSIBLE COMPLICATIONS OF A PROPOSED PSYCHOTROPIC MEDICATION OR SURGICAL PROCEDURE.
- A CLIENT IS INFORMED OF THE FOLLOWING: THE OUTCLIENT TREATMENT CENTERS POLICY ON HEALTH CARE DIRECTIVES, AND THE CLIENT COMPLAINT PROCESS.
- A CLIENT CONSENTS TO PHOTOGRAPHS OF THE CLIENT BEFORE A CLIENT IS PHOTOGRAPHED EXCEPT THAT A CLIENT MAY BE PHOTOGRAPHED WHEN ADMITTED TO AN OUTCLIENT TREATMENT CENTER FOR IDENTIFICATION AND ADMINISTRATIVE PURPOSES.
- EXCEPT AS OTHERWISE PERMITTED BY LAW, PROVIDES WRITTEN CONSENT TO THE RELEASE OF THE CLIENTS: MEDICAL RECORDS, AND FINANCIAL RECORDS, UNLESS OTHERWISE ALLOWABLE UNDER THE HIPAA.

A SAGE COUNSELING, INC. CLIENT HAS THE FOLLOWING RIGHTS:

- TO NOT BE DISCRIMINATED AGAINST BASED ON RACE, NATIONAL ORIGIN, RELIGION, GENDER, SEXUAL ORIENTATION, AGE, DISABILITY, MARITAL STATUS, OR DIAGNOSIS.
- TO RECEIVE TREATMENT THAT SUPPORTS AND RESPECTS THE CLIENTS INDIVIDUALITY, CHOICES, STRENGTHS, AND ABILITIES
- TO RECEIVE PRIVACY IN TREATMENT AND CARE FOR PERSONAL NEEDS.
- TO REVIEW, UPON WRITTEN REQUEST, THE CLIENTS OWN MEDICAL RECORD ACCORDING TO A.R.S. 12-2293, 12-2294, AND 12-2294.01
- TO RECEIVE A REFERRAL TO ANOTHER HEALTH CARE INSTITUTION IF THE OUTCLIENT TREATMENT CENTER IS UNABLE TO PROVIDE PHYSICAL HEALTH SERVICES OR BEHAVIORAL HEALTH SERVICES FOR THE CLIENT.
- TO PARTICIPATE OR HAVE THE CLIENTS REPRESENTATIVE PARTICIPATE IN THE DEVELOPMENT OF, OR DECISIONS CONCERNING TREATMENT.
- TO PARTICIPATE OR REFUSE TO PARTICIPATE IN RESEARCH OR EXPERIMENTAL TREATMENT.

- TO RECEIVE ASSISTANCE FROM A FAMILY MEMBER, REPRESENTATIVE, OR OTHER INDIVIDUALS IN UNDERSTANDING, PROTECTING, OR EXERCISING THE CLIENTS RIGHTS.

CLIENT COMPLAINT PROCEDURE:

SAGE COUNSELING, INC. HAS AN ESTABLISHED COMPLAINT PROCEDURE FOR CLIENTS. CLIENTS MAY FILE A COMPLAINT WITHOUT VIOLATION OF, OR THREAT OF VIOLATION OF, THEIR RIGHTS OR PRIVILEGES. CLIENTS ARE NOTIFIED OF THESE PROCEDURES AT THE TIME OF THEIR FIRST APPOINTMENT WITH SAGE COUNSELING, INC., AND THE AGENCY'S POLICY IS POSTED CONSPICUOUSLY IN SAGE COUNSELING, INC OFFICE LOBBY. THESE PROCEDURES ARE: IF A CLIENT HAS COMPLAINT REGARDING SERVICES RENDERED BY SAGE COUNSELING, THE CLIENT MAY BRING THESE CONCERNS OR COMPLAINTS DIRECTLY TO ANY CLINICAL STAFF MEMBER. THE STAFF MEMBER SHALL REPORT THE COMPLAINT TO THEIR SUPERVISOR. THE SUPERVISOR SHALL WORK WITH THE CLIENT TO RESOLVE THE CONCERN OR COMPLAINT. IF A RESOLUTION IS NOT AVAILABLE, OR IF THE CLIENT IS UNSATISFIED WITH THE RESOLUTION OPTIONS, SAGE COUNSELING SHALL PROVIDE THE CLIENT WITH ASSISTANCE ON ESCALATING THE COMPLAINT TO THE REFERRAL SOUNCE, AHCCCS, AND/OR THE ARIZONA DEPARTMENT OF HEALTH SERVICES, AS APPLICABLE. THE SUPERVISOR SHALL COMPLETE A CLIENT COMPLAINT FORM TO DOCUMENT THE COMPLAINT AND STEPS TAKEN TO RESOLVE THE ISSUE. A QI & COMPLIANCE DEPARTMENT EMPLOYEE MAY ASSIST OR LEAD IN THE TRIAGE OF A CLIENT COMPLAINT, AS NECESSARY. THE CONTACT INFORMATION FOR AZDHS & AHCCCS HEALTH PLANS ARE LISTED BELOW:

- ARIZONA DEPARTMENT OF HEALTH SERVICES BUREAU OF MEDICAL FACILITIES LICENSING
- 150 N.18TH AVE PHOENIX, AZ 85007
- (602) 542-1025
- BANNER UNIVERSITY HEALTH PLAN
- 2701 E. ELVIRA ROAD, TUCSON, AZ. 85756
- (800) 582-8686
- CARE1ST HEALTH PLAN ARIZONA, INC.
- 1870 W RIO SALADO PARKWAY, TEMPE, AZ. 85282
- (602) 778-1800 (866) | 560-4042
- ARIZONA DEPARTMENT OF ECONOMIC SECURITY DIVISION OF AGING AND ADULT SERVICES ADULT PROTECTIVE SERVICES
- 1366 EAST THOMAS ROAD, SUITE 108, PHOENIX, AZ. 85014
- PHONE: (602-264-2255)
- HEALTH CHOICE ARIZONA
- 410 N. 44TH ST., SUITE 900 PHOENIX, AZ 85008 (1-800-322-8670)
- ARIZONA DEPARTMENT OF ECONOMIC SECURITY DEPARTMENT OF CHILD SAFETY
- PO Box 6030, SITE CODE CH010-23A, PHOENIX, ARIZONA, 85005-6030
- HOTLINE 1-888-767-2445 | (602) 255-2500
- ARIZONA COMPLETE HEALTH MEDICAID MEMBER SERVICES
- (888) 788-4408
- MERCY CARE COMPLETE CARE
- 4500 E. COTTON CENTER BLVD., PHOENIX, AZ 85040
- (602) 263-3000 | (800) 624-3879
- MOLINA COMPLETE CARE
- 5055 E WASHINGTON ST., SUITE 210, PHOENIX, AZ. 85034
- (800) 424-5891
- UNITED HEALTHCARE COMMUNITY PLAN
- 1 EAST WASHINGTON, PHOENIX, AZ. 85004
- (800) 348-4058

FOR THE SAFETY OF OUR STAFF MEMBERS AND CLIENTS, THERE ARE SECURITY CAMERAS AT SOME OF OUR LOCATIONS. I ACKNOWLEDGE, BY SIGNING THIS DOCUMENT, THAT I MAY BE VIDEOTAPED IN COMMON AREAS FOR

SECURITY PURPOSES.

ETHICS & NOTICE OF SUPERVISION:

SAGE COUNSELING, INC. OPERATES WITH CERTAIN ETHICAL GUIDELINES IN PLACE FROM REGULATING BODIES, AND THEREFORE, OUR STAFF MEMBERS CANNOT ACCEPT GIFTS FROM CLIENTS, HAVE PERSONAL RELATIONSHIPS WITH CLIENTS, OR ATTEND PERSONAL CLIENT EVENTS. TO PROVIDE YOU WITH QUALITY SERVICES, SOME OF THE SAGE COUNSELING, INC. CLINICAL STAFF MEMBERS ARE BEING SUPERVISED BY A QUALIFIED CLINICAL SUPERVISOR LICENSED BY THE ARIZONA BOARD OF BEHAVIORAL HEALTH EXAMINERS (AZBBHE) IN THE PURSUIT OF LICENSURE PRIVILEGES. IF YOU HAVE ANY QUESTIONS OR COMPLAINTS ABOUT A PROVIDER, OR THE SERVICE YOU RECEIVE, PLEASE CONTACT THE DIRECTOR OF COMPLIANCE OF SAGE COUNSELING, INC. AT (480) 649-3352.

TELEHEALTH SERVICES & ENGAGEMENT:

SAGE COUNSELING, INC OFFERS SOME TREATMENT SERVICES THROUGH TELEHEALTH MODALITIES. I UNDERSTAND THAT IF I AM PARTICIPATING IN TELEHEALTH SERVICES, I AM REQUIRED TO ACTIVATE AUDIO ON MY DEVICE. I UNDERSTAND THAT IF MY DEVICE HAS VIDEO CAPABILITIES, I AM REQUIRED TO UTILIZE THAT FEATURE IN ORDER TO PROMOTE INCREASED ENGAGEMENT IN MY SERVICES.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT THERE MAY BE POTENTIAL RISKS ASSOCIATED WITH TELEHEALTH SESSIONS, INCLUDING POTENTIAL FOR DISRUPTION OF SESSION DUE TO TECHNOLOGY FAILURE. WHEN PARTICIPATING IN TELEHEALTH SESSIONS VIA TELEPHONE, I ACKNOWLEDGE THAT SAGE COUNSELING STAFF WILL VERIFY MY IDENTITY BY ASKING ME TO CONFIRM MY NAME AND DATE OF BIRTH. IN CASE AN EMERGENCY SITUATION ARISES, I ACKNOWLEDGE THAT I CAN CALL 911, TOLL-FREE NATIONAL SUICIDE PREVENTION LIFELINE AT 1-800-273-8255, OR ANY OF THE FOLLOWING ARIZONA COUNTY CRISIS LINES: APACHE COUNTRY: ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN AT 1-866-495-6735, COCHISE COUNTY: ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN AT 1-866-495-6735, COCONINO COUNTY: HEALTH CHOICE ARIZONA AT 1-877-756-4090, GILA COUNTY: HEALTH CHOICE ARIZONA AT 1-877-756-4090, GRAHAM COUNTY: ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN AT 1-866-495-6735, GREENLEE COUNTY: ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN AT 1-866-495-6735, LA PAZ COUNTY: ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN AT 1-866-495-6735, NAVAJO COUNTY: HEALTH CHOICE ARIZONA AT 1-877-756-4090, MARICOPA COUNTY: MERCY CARE AT 1-800-631-1314, MOHAVE: HEALTH CHOICE ARIZONA AT 1-877-756-4090, PIMA COUNTY: ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN AT 1-866-495-6735, PINAL COUNTY: ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN AT 1-866-495-6735, SANTA CRUZ COUNTY: ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN AT 1-866-495-6735, YUMA COUNTY: ARIZONA COMPLETE HEALTH - COMPLETE CARE PLAN AT 1-866-495-6735, YAVAPAI COUNTY: HEALTH CHOICE ARIZONA AT 1-877-756-4090, AK-CHIN INDIAN COMMUNITY AT 1-800-259-3449, GILA RIVER INDIAN COMMUNITY AT 1-800-259-3449, SALT RIVER PIMA MARICOPA INDIAN COMMUNITY AT 1-855-331-6432, TOHONO OODHAM NATION AT 1-844-423-8759 OR OTHER EMERGENCY RESPONSE PROVIDERS. I ALSO ACKNOWLEDGE THAT DURING SESSIONS CONDUCTED THROUGH TELEHEALTH, SAGE COUNSELING STAFF MAY REQUEST TO CONFIRM MY CURRENT LOCATION AND EMERGENCY CONTACTS IN ATTEMPT TO TRIAGE AN EMERGENCY SITUATION DURING A TELEHEALTH SESSION.

I AGREE TO PARTICIPATE IN MY TREATMENT PLANNING PROCESS TO THE BEST OF MY ABILITY AND WILL LET MY PROVIDER KNOW IF SITUATIONS OCCUR THAT PREVENT ME FROM PARTICIPATING IN TREATMENT. I UNDERSTAND THAT THIS CONSENT WILL REMAIN VALID SO LONG AS I AM ENROLLED IN A HEALTHCARE COVERAGE PLAN, SUCH AS THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS) OR A PLAN WITH ANOTHER HEALTHCARE PROVIDER. I UNDERSTAND THAT BY SIGNING THIS CONSENT FORM, I AM GIVING PERMISSION TO THE ARIZONA DEPARTMENT OF HEALTH SERVICES, ALL MEMBERS OF MY CLINICAL TREATMENT TEAM, AND MY HEALTHCARE PLAN TO ACCESS MY INFORMATION AND RECORDS. I AUTHORIZE INFORMATION THAT SAGE COUNSELING, INC. HAS GATHERED FROM OTHER THIRD PARTY SOURCES TO BE SHARED WITH MY HEALTH PLAN. I UNDERSTAND THAT ALL OF THE INFORMATION

GATHERED IN THE COURSE OF TREATMENT IS CONFIDENTIAL. HOWEVER, CONFIDENTIAL INFORMATION MAY BE DISCLOSED WITHOUT MY CONSENT ACCORDING WITH STATE AND FEDERAL LAW.

FEES & FINANCIAL RESPONSIBILITY:

SAGE COUNSELING PROVIDES A FEE SCHEDULE SPECIFIC TO EACH CLIENT PRIOR TO THE DELIVERY OF RECOMMENDED SERVICES. BY SIGNING THIS FORM I ACKNOWLEDGE BEING INFORMED OF MY FEE SCHEDULE, AND UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL FEES ASSOCIATED WITH THE SERVICES DELIVERED TO ME BY SAGE COUNSELING. IN SOME INSTANCES, SERVICES OFFERED BY SAGE COUNSELING MAY BE PAID FOR THROUGH A 3RD PARTY OR INSURANCE PLAN. I FURTHER ACKNOWLEDGE THAT ANY SERVICES NOT PAID FOR BY A 3RD PARTY OR INSURANCE PLAN BECOME MY FINANCIAL RESPONSIBILITY. IF AT ANY TIME I HAVE PAID AN EXCESS AMOUNT TO SAGE COUNSELING, A REFUND WILL BE OFFERED IN ACCORDANCE WITH THE SAGE COUNSELING REFUND POLICY. BY SIGNING BELOW, I ATTEST THAT I AM THE CLIENT ASSOCIATED WITH THIS RECORD, OR THE AUTHORIZED LEGAL GUARDIAN OF THE CLIENT.

BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ THIS INFORMED CONSENT DOCUMENT AND AGREE TO ITS TERMS. I ACKNOWLEDGE MY RIGHTS AND RESPONSIBILITIES AS A CLIENT AND VOLUNTARILY SUBJECT MYSELF TO TREATMENT PROVISIONS OFFERED BY SAGE COUNSELING, INC. I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED A COPY OF MY RIGHTS AS A SAGE COUNSELING CLIENT. I AGREE TO RELEASE AND HOLD HARMLESS SAGE COUNSELING, INC. FOR ANY DAMAGES INCURRED THROUGH PARTICIPATION OR NON-PARTICIPATION IN TREATMENT SERVICES.

If you would like information on other services offered by SAGE or information on AHCCCS eligibility, please call 480-649-3352

By signing below, I acknowledge that I have read and understand the SAGE Counseling, Inc. Standards of Conduct. Furthermore, I agree to abide by the Standards of Conduct and voluntarily subject myself to any potential consequence of my non-compliance to the Standards of Conduct.

Please sign using your full name

Client's Full Name

Date of Signature

Health Leads Screening Toolkit

Patient Name
Date of Birth
Preferred Language
Phone Number
Best time to call

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?*

☐ Yes ☐ No

In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home?

☐ Yes ☐ No

Are you worried that in the next 2 months, you may not have stable housing? ☐ Yes ☐ No

Do problems getting child care make it difficult for you to work or study? (leave blank if you do not have children)

☐ Yes ☐ No

In the last 12 months, have you needed to see a doctor, but could not because of cost? ☐ Yes ☐ No

Do you have problems getting to/from work, school, or medical appointments due to lack reliable transportation?

☐ Yes ☐ No

Do you ever need help reading hospital materials? ☐ Yes ☐ No

Do you often feel that you lack companionship? ☐ Yes ☐ No

Do you feel unsafe in your living environment? ☐ Yes ☐ No

Do you lack a stable source of income? ☐ Yes ☐ No

Are any of your needs urgent? (for example: I don't have food tonight, I don't have a place to sleep tonight)

☐ Yes ☐ No

If you checked YES to any boxes above, would you like to receive assistance with any of these needs? ☐ Yes ☐ No

Medication List

Client Name
Date of Birth

List of Medication

Table

Medication Name	Purpose	Dosage	Date Started	Prescribing Doctor