Acknowledgment and Consent Agreement

The following Acknowledgement and Consent Agreement is hereby made by the person executing this agreement whether signing as a subscriber, guardian, guarantor, agent, or as a patient, (hereinafter "Signatory") and is a condition of receipt of Services by Pine Tree Recovery Center, LLC ("Pine Tree Recovery Center"). By executing this Acknowledgement and Consent Agreement ("Agreement"), Signatory explicitly consents to all terms and conditions contained herein. The Effective Date shall be the date executed by the Signatory herein.

- **Description of Services.** Signatory understands that Pine Tree Recovery Center is an out-of-network provider of treatment services related to the treatment of substance use disorder. Pine Tree Recovery Center is licensed by the State of Maine's Department of Health and Human Services to provide treatment services at the following levels: Intensive Outpatient.

- **Voluntary Admission.** Signatory voluntarily consents to admission to Pine Tree Recovery Center for substance abuse and mental health treatment services. Signatory understands that he/she should be in reasonable good health as assessed by Pine Tree Recovery Center prior to receipt of Services. The signatory represents that he/she is over the age of 18.

- **Medical Consent.** The Signatory hereby voluntarily consents to any and all medical treatment, counseling services, psychological services, and/or any other services rendered at Pine Tree Recovery Center, by its physicians, staff, clinical personal, and others, including authorized ancillary providers. This may include, but is not limited to, the following:
  Intensive Outpatient Services: Individual, group and/or family therapy. At a minimum nine (9) hours per week and may include the following:
    - Substance abuse education
    - Urine Drug Screen and/or Urine Drug Test services
    - Life skills training
    - Aftercare planning
    - Mental health services
    - Relapse prevention services

- **Conditions of Treatment.** Signatory voluntarily acknowledges and understands that treatment of substance abuse and mental health conditions is not an exact science and that no promises or guarantees have been made regarding the final outcome or success of treatment.

- **Use of Non-Prescribed Drugs, Illegal Drugs; Representative Clothing.** Signatory agrees to abstain from the use of any and all illegal/ non-prescribed substances and alcohol while at Pine Tree Recovery Center and understands that absolutely no alcohol, drugs, or drug paraphanalia are permitted on camera while in session. Signatory agrees that wearing any clothing, items, or displays in session, any personal belongings that glorifies or endorses the use of drugs and alcohol subjects Signatory to immediate discharge from the facility.

- **Suicide or Self Harm.** The signatory agrees that he/she will not in any way attempt suicide, injury, or self-harm while seeking treatment at Pine Tree Recovery Center. Signatory understands that any attempts at suicide or self-harm shall be treated very seriously and shall result in an immediate call to 911 and possible transfer to a more appropriate facility. The signatory agrees to disclose any suicidal ideations, dangerous thoughts, or feelings, as well as any intent to injury him/herself to a staff member.

- **Medications.** Signatory agrees to the following: (i) to take medication as prescribed; (ii) to commit to participation and recognition of a positive attitude towards treatment; and (iii) that any medication not approved by Pine Tree Recovery Center's physicians or psychiatrist within three (3) days of admission will be discontinued.

- **Third-Party Referrals.** Signatory acknowledges that certain circumstances may require the referral of

- **Third-Party Referrals.** Signatory acknowledges that certain circumstances may require the referral of services to a third-party treatment center, laboratories, psychiatrists, or other medical providers and consents thereto. Signatory may refuse such referrals. Signatory alone bears the financial responsibility for such referrals. Under no circumstances shall Pine Tree Recovery Center be financially responsible in any way whatsoever for any third-party referrals.

- **Emergency Treatment and/or Hospital Transfer Consent.** Signatory understands that while at Pine Tree Recovery Center, the need for emergency treatment and/or transfer to a hospital or mental health facility may become necessary and appropriate. Should the need for such treatment and/or transfer be deemed necessary and appropriate by the attending physician, assistants, or other clinical personnel of Pine Tree Recovery Center, the Signatory voluntarily consents to such emergency treatment and/or transfer to a hospital or mental health facility. Under no circumstances shall Pine Tree Recovery Center be financially responsible in any way whatsoever for any resulting transfer.

- **Testing Consent.** Signatory understands that as part of the Services offered by Pine Tree Recovery Center, the submission of drug screen testing for alcohol and drug content, pregnancy testing, tuberculin testing (PPD and/or chest x-ray), psychological testing, breathalyzer, urine, and other such similar procedures is required. As such, the Signatory hereby provides his/her consent for Pine Tree Recovery Center to perform such services at its discretion. The signatory also understands and consents that such testing may include giving a urine sample in the presence of staff at any time if requested. Signatory agrees to authorize insurance payments to be made to Pine Tree Recovery Center's laboratory for the laboratory services ordered by my practitioner. Signatory agrees to authorize the pracitioner and practice staff, as well as insurance company (if any) to release Pine Tree Recovery Center's Laboratory and it's agents, any information needed to determine benefits for laboratory services. Signatory understands that they are responsible for payment of any deductibles or co-insurance charges. If the self-pay box is marked, Signatory accepts full responsibility for the payment associated with these laboratory services. Signatory understands that refusal to submit to testing when requested will be considered a positive result and may lead to discharge from the program.

- **Video Monitoring and Surveillance.**Signatory understands and acknowledges that, while under the care of Pine Tree Recovery Center, telehealth sessions may be recorded and stored in a secure location. This is to ensure client safety and security. Footage will only be reviewed internally under special circumstances, including emergencies and formal investigations, and will never be shared with entities outside of Pine Tree Recovery Center, unless under the circumstance of a court order. An expectation of decency and privacy to protect clients at vulnerable times is inclusive of this policy, and is managed with the utmost care.

- **Rules and Regulations.** Signatory hereby agrees to comply with and abide by all policies, rules, and regulations of Pine Tree Recovery Center. Signatory has been provided a handbook of procedures, rules, and his/her rights, and acknowledges receipt of the same. The signatory understands that he/she must read the handbook within twenty-four (24) hours of receipt.

- **Confidentiality of Others.** Signatory understands that information may be shared within a group setting when Services are being rendered which may contain or relate to the confidential information of others. Signatory agrees that during the program, shall not discuss, disclose, or reveal confidential information of others, including others who are undergoing treatment at Pine Tree Recovery Center.

- **Confidential Human Immunodeficiency Virus (HIV) Test.** As part of the Services offered by Pine Tree Recovery Center, Signatory shall submit to HIV testing, unless it explicitly refuses such testing. Under the current law of the State of Maine, Pine Tree Recovery Center is required to screen and identify persons who are considered “high risk”. Signatory understands that it may refuse such testing. HIV testing is a process that uses FDA-approved tests to detect the presence of HIV, the virus that causes AIDS, and to see how HIV is affecting your body. The most common type of HIV test detects antibodies produced by the body after HIV infection. Test results are highly reliable but a negative test does not guarantee that

you are healthy. Generally, it can take up to three months for HIV antibodies to develop. This is called the "window period". During this time, you can test negative for HIV even though the virus is in your body and you can give it to others. A positive antibody HIV test means that you are infected with HIV and can also give it to others even when you feel healthy. Other tests can detect the presence of the virus in your blood, measure the amount of virus in your blood, measure the number of T-cells in your blood, or see if the virus is susceptible to HIV/AIDS medications. Some of these tests may require a second specimen to be obtained for further testing. Generally, test results will be available in about 2 weeks.
If you consent by signing this form a specimen will be taken and you will be tested. If a rapid HIV test is used, results will be available the same day. If the rapid test detects HIV antibodies, it is very likely that you are infected with the virus, but this result will need to be confirmed. You will be asked to submit a second specimen for further testing. The results from this confirmatory test will be available to you in about 2 weeks. If you test positive, the local health department will contact you to help with counseling, treatment, case management, and other services if you need them and want them. You will be asked about sex and/or needle-sharing partners, and voluntary partner counseling and referral services (PCRS) will be offered to you. The HIV test result will become part of your confidential medical record. If you are pregnant or become pregnant, the test results will become part of your baby's medical record. Finding HIV infection early can be important to your treatment, which along with proper precautions, helps prevent the spread of the disease. If you are pregnant, there is treatment available to help prevent your baby from getting HIV. If you have any questions, please ask your counselor, physician, or call the Maine AIDS Hotline at (800) 851-2437 before signing this form.

- **Consent for Reporting of Communicable Diseases.** Signatory hereby consents to the release to the Maine CDC of any information regarding the diagnoses or suspected existence of a communicable disease within forty-eight (48) hours of the diseases or conditions listed below:

Limitations of Confidentiality of Medical Information/ Legal Reporting Requirements. Signatory understands that his/her medical and health-related information is private and confidential and governed by Federal and State confidentiality regulations (including but not limited to P.L 104-191, 42 USC Section 1320d et Seq 42 USC 290dd-3; 42 USC 290ee-3; 42 CFR Part 2) as well as Pine Tree Recovery Center's "Notice of Privacy Practices" which list in greater detail information pertaining to the use and release of medical and health-related information.
The Signatory understands that there are limitations on the requirement of confidentiality. Some of these are: (i) Signatory consents in writing; (ii) disclosure is allowed by a court order; (iii) disclosure is made to medical personnel in the course of treatment or a medical emergency; (iv) disclosure to qualified personnel for research, audit or program evaluation; (v) suspected child or elderly abuse or neglect from being reported under State law to appropriate State or local authorities; (vi) any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime; and (vii) any threats to self or to others.
Conflicts of Interest and Freedom of Choice. If referred to Pine Tree Recovery Center by another service provider, with which, Pine Tree Recovery Center may have a financial relationship, Signatory is aware and acknowledges that he/she has the freedom to decline or choose services as he/she desires and has the right at any time to decline services and/or seek another service provider without any difference in treatment or services rendered.

Media Consent. Signatory hereby provides consent to have his/her photograph, video, or other forms of media taken while at Pine Tree Recovery Center.

Discharge Follow-up. Signatory hereby consents to contact by Pine Tree Recovery Center via email, writing, telephone after discharge, for the purposes of follow-up, questionnaire, or alumni information.

Notice of Subsidiary Affiliation. Signatory understands that Pine Tree Recovery Center is in the network of companies under Guardian Recovery Network Holdings, LLC (Guardian Recovery Network). Signatory understands that any valid Authorizations Relating to Protected Health Information permit any company within the Guardian Recovery Network organization to employ these authorizations, in any manner deemed appropriate and

consistent with applicable law, for the purpose(s) as defined within. Signatory understands that these authorizations will remain valid throughout my course of stay at any subsidiary of Guardian Recovery Network.

Client Rights and Grievance Procedure. Signatory acknowledges receipt of Pine Tree Recovery Center's Client Handbook containing a list of client rights as defined in state statute. Signatory understands that if at any time, they feel as though their rights have been violated, they reserve the right to file a formal grievance with the state governing body. Signatory understands the grievance procedure and acknowledges receipt of information regarding appropriate agencies to contact in the event they would like to file a formal grievance, which is also included in the client handbook.

Client Responsibilites. The following are expectations/responsibilities of clients admitted to Pine Tree Recovery Center;

1. Provide accurate and complete information about present complaint(s), past illnesses, hospitalizations, medications, and other matters related to health, perceived risks of care at Pine Tree Recovery Center and to notify staff immediately with any unexpected changes in health. The client should also provide staff feedback regarding the care received, service needs and/or expectations.
2. Clients are responsible for asking questions when they do not understand what they have been told about their care or what they are expected to do.
3. Comply with treatment recommedations by the primary care practitioner. Clients should express any concerns about their ability to comply with the treatment plan.
4. Comply with facility rules and regulations that affect client care and conduct.
5. Assume responsibility for actions of refusing treatment or not complying with facility recommendations.
6. Show consideration of the rights of other clients and facility personnel and their property.
7. Assure that financial obligations for health care are fulfilled as promptly as possible.

General Consent. Signatory understands by participating in the program at Pine Tree Recovery Center, he/she must agree and consent to receive, participate in, be actively engaged, and accept the risk of any service, interaction, activity, or other item related to the program at Pine Tree Recovery Center and hereby consents and agrees to such participation and liability herein.
By signing below, I affirm and assert that I have read and understood the terms and conditions of this Acknowledgement and Consent Agreement.
Client Name: Nine
Client Signature:
Date:

Authorization to Obtain and/or Release Information

I, Nine, understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

I understand that this Authorization Relating to Protected Health Information authorizes any company within the Guardian Recovery Network Holdings, LLC organization to employ this authorization, in any manner deemed appropriate and consistent with applicable law, for the purpose(s) as defined below.
I understand that this authorization will remain valid throughout my course of stay at any subsidiary of Guardian Recovery Network Holdings, LLC. This release may be rescinded at any time during this episode of care or at any time up to the expiration of the release.
I hereby authorize Pine Tree Recovery Center to release, disclose, obtain copies of the following confidential information to the following person or agency, and/or its representative or entity.
Relationship to Patient:
☑ Spouse ☐ Parent ☐ Step-Parent ☐ GrandParent ☐ Friend ☐ Child
☐ Sibling ☐ Legal Guardian ☐ Uncle ☐ Aunt ☐ Relative ☐ Other
I specifically authorize:
☐ The release of and/or ☐ The obtainment of
☐ Presence in treatment ☐ Progres in treatment ☐ Treatment plans ☐ Psychological assessment ☐ Psychiatric history and assessment ☐ Results of physical exam
☐ Medical history/current status ☐ Biopsychosocial assessment ☐ Laboratory test results ☐ Employment Information ☐ Criminal History ☐ Family Information
☐ Aftercare recommendations ☐ Discharge planning ☐ Discharge summary
Purpose
☐ Continuity of treatment - Patient history - Case Management services ☐ General Updates ☐ Emergency contact ☐ Court services - Legal purposes - Probation - Disability claiming - Unemployment claiming - Employment continuity ☐ Payment related issues ☐ Other

Expiration

Unless sooner revoked, this consent is valid for **12 months** due to the need for ongoing communication for thecoordination of treatment, or at termination of treatment.

Conditions

I understand that Pine Tree Recovery Center will not condition my treatment on whether I give authorization for therequested disclosure. The consequences of refusing to sign this authorization have been explained to me.

Form of Disclosure

Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem to be appropriate and consistent with applicable law, including but not limited to verbally, in paper format, or electronically.

RE-DISCLOSURE

"This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information in NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse Client."
I may request a copy of this authorization for my records.

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2). Published August 10. 1987, and the Heath Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug and alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. (Under the Mental Heath Code, release of mental health records must be germane to the purpose and need for disclosure).

RIGHT TO REVOCATION

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to PineTree Recovery Center. I further understand that a revocation of the authorization is not effective to the extent that actionhas been taken in reliance on the authorization.

Signature:

Date:

Authorization for Follow-Up Communication

I Nine, authorize the staff of Pine Tree Recovery Center to provide ongoing support following my discharge by communicating with me in the forms of:

☑ Phone ☐ Email ☐ Text Communication ☐ Social Media ☐ Events ☐ Paper Mail

If yes, whom may we contact?

I, Nine, understand that this consent does not have an expiration date and will remain active until otherwise revoked by me to Guardian Recovery Network staff.

I understand that I have the right to revoke this Authorization at any time pursuant to Pine Tree Recovery Center's Notice of Privacy Practices, except to the extent that Pine Tree Recovery Center has already acted in reliance on the Authorization. I understand that I may revoke this Authorization verbally or in writing to the individual(s) responsible for Pine Tree Recovery Center discharge follow-up and alumni engagement.

** **

I understand that after I am discharged from my treatment at Pine Tree Recovery Center, regardless of any post-discharge communication, Pine Tree Recovery Center owes me no continuing duty of care or treatment. Additionally, I hereby release Pine Tree Recovery Center from any and all future liability, consequential or direct or otherwise not listed herein, however contemplated. I understand that if I am in need of immediate help or am experiencing suicidal thoughts, I must call 9-1-1 or seek immediate help from a qualified healthcare provider.

** **

I understand that my treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed to any party without my written consent unless otherwise provided for by the regulations.

** **

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, or otherwise altered, rendered incomplete or fail to be delivered. As the electronic transmission of information cannot be guaranteed to be secure or error-free and the confidentiality of your participation in the Pine Tree Recovery Center program(s) may be vulnerable, Pine Tree Recovery Center shall not have any responsibility or liability with respect to any error, omission, claim or loss, arising from or in connection with the electronic communication of Pine Tree Recovery Center to me.

** **

I understand that my confidentiality, and the confidentiality of others, is of the utmost importance. By agreeing to participate in continued communication with Pine Tree Recovery Center, I agree to not share or disclose the identity or personal information of other individuals I may be in contact with through Pine Tree Recovery Center's electronic communication and/or events.

** **

Pine Tree Recovery Center cannot control other individual's actions in discussing or sharing any self-disclosed personal information in group settings, thus I agree that I will not hold Pine Tree Recovery Center liable for possible further sharing of information by other participants of alumni groups or events.

** **

I agree that Pine Tree Recovery Center may communicate with me electronically unless and until I revoke this authorization. This authorization does not allow for the release of any protected health information.

By signing below, I, Nine, certify that I understand and agree to the above, have been offered a copy of, and amthe individual providing the aforementioned authorization.

Client Name: Nine

Client Signature:

Date:

RI 02 - Complaints and Grievances	POLICY/REVISED DATE:04/01/19;4/1/22	
3.7d 3.5 2.5 2.1	RI.01.01.01;EP-2, RI.01.07.01;EP 1,2,4,7,10	21.180
Joshua Scott Chief Executive Officer	10.161A-17.3 10:161B-16.3	65D-30.004(29) F.S. 397.501(1-10)
	Ch. 5:5.4	He-P 826.18(s)(8)

POLICY:

It is the policy of this facility to ensure that individuals applying for or receiving substance use services are guaranteed the protection of fundamental human, civil, constitutional, and statutory rights.
The grievance will be tracked and logged until resolved or concluded by actions of the provider's governing body. Analysis of trends to identify opportunities for improvement will be conducted and submitted to the QA Committee quarterly meeting.

AGENCY GRIEVANCE PROCEDURE:

1) All Individuals will be given a copy of the telephone number to the Abuse Hotline and State Licensing Authority's Program Office at the time of admission. All Individuals will be afforded the opportunity to contact any of the above phone numbers without fear of retaliation. The telephone number of the hot line is posted in the Common Room.
2) Any person(s) who believes that his / her rights have been violated or has a complaint or grievance may file a complaint pursuant to the procedures set forth below, on his / her behalf, or on the behalf of another person. All persons are encouraged to file a complaint and/or grievance. By filing a complaint, the individual will not subject themselves to any form of adverse action, reprimand, retaliation, or otherwise negative treatment by this facility. Individuals shall have immediate access to the grievance form located in the group room.
  The grievance procedure will be in the first-floor lounge area with the levels of appeals, and in the Individual handbook.
3) To register a grievance, the following steps will be followed:

1. Individuals, family members, and authorized guardians of an Individual's rights and responsibilities shall be informed of his / her rights and responsibilities during the orientation, have knowledge of the grievance system, be assured that the can file a grievance at any time, and be knowledgeable of where the notice of grievance is located and where the forms are.
2. Grievance Forms are in the reception and a common area. The Grievance Form will be discussed with the Individual with 24 hours of the Grievance Form being given to the therapist.
3. Individuals are encouraged to discuss any problems with their primary therapist. The Individual and therapist will try to find a resolution within 24 hours.
4. If the Individual is not satisfied with the results, the Individual will meet with the Clinical Director within 24 hours of the date of meeting with the therapist. The Clinical Director will meet with the Individual's primary therapist.
5. The decisions made regarding the grievance are considered final at this point and will be documented and submitted to the Individual in writing.
6. If the Individual is dissatisfied at this point, the Individual has the right to contact the State Abuse Registry.
7. Individual's grievance and a final internal step in the grievance process and decision is resolved or concluded by action this facility's Governing Board.
8. If an Individual does not feel a resolution has been reached, they may contact the State Licensing Authority.

4) Any allegations of physical or sexual abuse by a staff member shall be brought to the immediate attention of the Clinical Director.

1. The Individual will be afforded the opportunity to contact the Abuse Hotline and The State Licensing Authority. The contact information for the abuse registry, Disability Rights, and the State Licensing Authority's Program Office will be posted in a common area.
2. Notification to all parties of these rights shall include affirmation of an organizational non-relationship policy that protects a party's right to file a grievance or express his / her opinion and invokes applicability of state and federal protections.

5) The Clinical Director and the CEO shall take steps to ensure an appropriate investigation of each complaint to determine its validity. These rules contemplate informal, but thorough, investigations, affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to the complaint.
6) If an Individual is dissatisfied at any point, the Individual has the right to voice complaints, questions or concerns about service, treatment, procedures, rights, and policies by calling any one of the agencies posted in the common areas of the facility (See Appendix)

RI-02 Appendix

State Specific Abuse Reporting Numbers:

- Colorado Child Abuse and Neglect Hotline (844) CO-4-Kids
- Maine Department of Health and Human Services - Aging and Disability Services (207) 287-3492
- New Hampshire DHHS - Bureau of Elderly and Adult Services (603) 271-7014
- New Jersey Abuse Registry (877) 712-1868
- Florida Abuse Registry (800) 962-2873

The U.S. Department of Health and Human Services for privacy or confidentiality violations (HIPAA):

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775
Client Name: Nine
Client Signature:

Date:

Assignment of Benefits

I, Nine, whether signing as subscriber, guardian, guarantor, agent, or as patient, (hereinafter "Signatory"), hereby irrevocably assign and transfer to Pine Tree Recovery Center, LLC, and/or any of its affiliated companies, partner companies, subsidiaries, sister-companies, holding companies, divisions, or other forms of related ownership, owned in whole or in part by Pine Tree Recovery Center, LLC, and/or its majority interest holders (collectively referred to as the "Assignee" or "Pine Tree Recovery Center, LLC"), its successors, agents and assignees as my beneficiary all rights to any and all insurance benefits which are or may become due to me, together with any and all actions, causes and action, suits, debts, sums or money, accounts, covenants, contracts, promises and interest in, or which I might acquire an interest against TEST INSURANCE ("Insurance Carrier"), in accordance with its obligations to me arising under a certain policy of insurance (under which I am either the insured, subscriber or a covered dependent) for hospital, medical, chemical or substance abuse dependency services and other health care services ("Services") rendered by the Assignee.

To be clear, I hereby authorize and request the Insurance Carrier to pay directly to Assignee the amount due to me for any and all claims for Services rendered and appoint Assignee to act as my representative on behalf of any proceeding that may be necessary to seek payment from the Insurance Carrier.

I authorize Assignee all rights to appeal, communicate, obtain any and all files, papers, documents, correspondence, determinations, including, but not limited to, any and all reports, plan becorrespondence, billing records, payment ledgers, insurance cards or other health insurance information, appeal determinations and any and all documents whatsoever in the Insurance Carrier, and/or its agents', possession pertaining to the Services rendered by Pine Tree Recovery Center, LLC, as well as all other acts which may be helpful and appropriate to the accomplishment of such purposes, for the ultimate objective of Pine Tree Recovery Center, LLC's payment for Services and shall cooperate as needed with Assignee to obtain any information necessary to complete such purposes.

I authorize Assignee all rights to institute, prosecute and/or defend litigation, arbitration and/or other dispute resolution proceedings against my Insurance Carrier, and/or third party payers, including but not limited to any and all administrative appeals which may be a condition precedent to litigation and/or any other dispute resolution proceedings, and to settle or compromise all claims and/or disputes with my Insurance Carrier, and/or third party payers, for claims related to Services rendered by Assignee. This includes, but is not limited to, acting on my behalf as my authorized representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.503-1(b)(4), with respect to any healthcare expenses incurred as a result of the services I received from Assignee.

I have been made aware of my rights under HIPAA, and all other applicable Federal and State regulations pertaining to the release of my health information and private confidential records. With said knowledge, I authorize Assignee to disclose any and all written information to the Insurance Carrier and/or its designated representatives, or other third party, as necessary and as determined by Assignee. Such disclosure shall be for reimbursement purposes for Services provided by Assignee. I have executed an Authorization Relating to Protected Health Information which may be provided if necessary.

I hereby indemnify and hold the Assignee harmless against any and all claims that have arisen or may arise with respect to the subject matter of this Assignment of Benefit. I also release Assignee its parent corporation, affiliates, subsidiaries, divisions, officers, agents, employees and any clinician, from any and all liability that may arise as a result of disclosure of information to the above named Insurance Carrier or its designated representatives or other third parties.

Should the benefits with the Insurance Carrier be "Non-assignable", I acknowledge and agree that any payments made to me directly by the Insurance Carrier for Services rendered are trust funds to be delivered Assignee. I also acknowledge and agree herein that I have no ownership, title or property interest in the insurance check(s) issued for payment of Services provided by Assignee and that I do

hereby assign ownership or any related interest(s) in these funds to Assignee.

Moreover, I agree that if I receive any payment(s) for Services rendered by Assignee from the Insurance Carrier directly, upon receipt, I will mail the payment check(s) or draft to Assignee. I further agree to endorse the payment check(s) payable to Assignee. In the alternative, my signature on this document authorizes any officer, director or employee of Assignee to endorse any check(s), draft(s) or other negotiable instrument(s) representing insurance or third party proceeds payable in connection with Services rendered by Assignee.

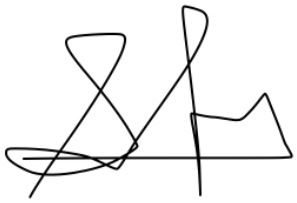
I understand that should I fail to forward check(s) received and my account may be referred to a credit agency, skip tracing agency, debt collector and/or an attorney for collection, I shall pay reasonable attorneys' fees and costs and all expenses whether or not suit be brought, associated with collection of amounts due and owing.

I understand that the Insurance Carrier may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this Assignment of Benefits as per the terms of and conditions of the Financial Agreement with Assignee. I also understand that this assignment does not release any obligation regarding payment of Patient Responsibility.

I agree to cooperate with Assignee in anyway necessary to ensure that it is paid for the Services rendered. By signing below, I affirm and assert that I have read and understood the terms and conditions of this Assignment of Benefits.

Client Name: Nine

Client Signature:



Date:

17-September-2022

Teen Challenge Southeast Region

COVID-19 Policy

I, Nine, hereby agree to adhere to all Covid-19 policies while at Pine Tree Recovery Center, LLC.

I understand that while I am in treatment at Pine Tree Recovery Center, LLC, I am expected to:

Please initial the following statements:
☐ I have read Immersion Recovery Center, LLC Covid-19 policies.
☐ I understand that I must wear a mask at all times while in the facility.
☐ I will maintain CDC social distancing guidelines
☐ I understand the violation of these policies may result in administrative discharge
☐ I understand If I receive a negative result from my initial test for COVID-19, I could still develop symptoms at a later date

The above conditions have been explained to me and I fully understand my obligations while in treatment at Pine Tree Recovery Center, LLC and agree to abide by the conditions stated above

Client Name: Nine

Client Signature:

Date:

24-November-2022

Teen Challenge Southeast Region

COVID-19 Policy

I, Nine, hereby agree to adhere to all Covid-19 policies while at Pine Tree Recovery Center, LLC.

I understand that while I am in treatment at Pine Tree Recovery Center, LLC, I am expected to:

Please initial the following statements:
☑ **I have read Immersion Recovery Center, LLC Covid-19 policies.**
☑ **I understand that I must wear a mask at all times while in the facility.**
☐ I will maintain CDC social distancing guidelines
☐ I understand the violation of these policies may result in administrative discharge
☐ I understand If I receive a negative result from my initial test for COVID-19, I could still develop symptoms at a later date

The above conditions have been explained to me and I fully understand my obligations while in treatment at Pine Tree Recovery Center, LLC and agree to abide by the conditions stated above

Client Name: Nine

Client Signature:

Date:

02-February-2023

Teen Challenge Southeast Region

Testing Line 1,
Columbus Eastern, 31902

Authorization to Release Information

Name: **Nine2 Nine2** DOB: **02-Jan-2005** SSN: **XXX-XX-1231**

I hereby authorize Teen Challenge Southeast Region to release information to and receive information from:

Name:

Phone:

Address:

Fax:

By initialing the spaces below, I specifically authorize the release of this confidential information:

Acknowledge Participation (including SUD Information)

Encounter Detail (including SUD Information)

Attendance & Participation (including SUD Information)

Medical Chart Note (including SUD Information)

Client Information (Profile)

Medication Summary (including SUD Information)

Diagnosis List (including SUD Information)

Mental Health Assessment (including SUD Information)

Discharge Information (including SUD Information)

Prognosis (including SUD Information)

Drug Test Results (including SUD Information)

Substance Use Disorder Assessment

Emergency & Urgent Care Records

Treatment Pan/Review (including SUD Information)

Other (Specify)

This information will be used for the following purpose:

Care Coordination

I understand that my treatment records are protected under federal and state regulations (42 CFR Part 2) governing Confidentiality of Substance Use Disorder (SUD) Patient Records and Mental Health Records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that authorizing disclosure of confidential information to an entity not covered by federal regulations (i.e. friend/family) may result in additional disclosure. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 90 days following discharge from treatment at Teen Challenge Southeast Region or at the later following date:

Date:

12-December-2022

I understand I have the right not to sign this authorization and choosing not to sign will not affect my ability to obtain treatment, payment, or eligibility for health care benefits:

Client Name: **Nine2 Nine2**

Client Signature:

Date:

12-December-2022

Signature of guardian or authorized representative when required

Teen Challenge Southeast Region

Testing Line 1,
Columbus Eastern, 31902

Authorization to Release Information

Name: **Nine2 Nine2** DOB: **02-Jan-2005** SSN: **XXX-XX-1231**

I hereby authorize Teen Challenge Southeast Region to release information to and receive information from:

Name:

Phone:

Address:

Fax:

By initialing the spaces below, I specifically authorize the release of this confidential information:

Acknowledge Participation (including SUD Information)

Encounter Detail (including SUD Information)

Attendance & Participation (including SUD Information)

Medical Chart Note (including SUD Information)

Client Information (Profile)

Medication Summary (including SUD Information)

Diagnosis List (including SUD Information)

Mental Health Assessment (including SUD Information)

Discharge Information (including SUD Information)

Prognosis (including SUD Information)

Drug Test Results (including SUD Information)

Substance Use Disorder Assessment

Emergency & Urgent Care Records

Treatment Pan/Review (including SUD Information)

Other (Specify)

This information will be used for the following purpose:

Care Coordination

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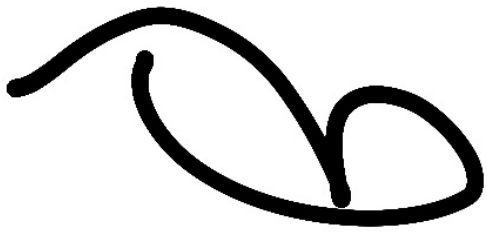
Date:

12-December-2022

I understand I have the right not to sign this authorization and choosing not to sign will not affect my ability to obtain treatment, payment, or eligibility for health care benefits:

Client Name: **Nine2 Nine2**

Client Signature:



Date:

12-December-2022

Signature of guardian or authorized representative when required

Authorization to Obtain and/or Release Info (ROI)

I, Nine Nine, understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2) published August 10, 1987, and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions.

I understand that this Authorization Relating to Protected Health Information authorizes any company within the Guardian Recovery Network Holdings, LLC organization to employ this authorization, in any manner deemed appropriate and consistent with applicable law, for the purpose(s) as defined below.

I understand that this authorization will remain valid throughout my course of stay at any subsidiary of Guardian Recovery Network Holdings, LLC. This release may be rescinded at any time during this episode of care or at any time up to the expiration of the release.

I hereby authorize Pine Tree Recovery Center to release, disclose, obtain copies of the following confidential information to the following person or agency, and/or its representative or entity.

Name of Person/Agency: **jhhj**

Address: **jhjhg**

City: **hjghj**

State: **gjhgjhghj**

Zip: **ghjgjh**

Phone: **gjhgjhgjh**

Cell Number: **ghjghjg**

Fax Number: **hjgjhgjhgjh**

Email Address: **gjhgjhgjh**

Relationship to Patient:

☑ **Spouse** ☑ **Parent** ☑ **Step-Parent** ☑ **GrandParent** ☑ **Friend** ☐ Child

☑ **Sibling** ☑ **Legal Guardian** ☑ **Uncle** ☑ **Aunt** ☑ **Relative**

Other:

I specifically authorize:

☑ **The release of and/or** ☑ **The obtainment of**

☑ **Presence in treatment** ☑ **Progress in treatment** ☑ **Treatment plans**
☐ Psychological assessment ☑ **Psychiatric history and assessment**
☑ **Results of physical exam**

☑ **Medical history/current status** ☑ **Biopsychosocial assessment** ☑ **Laboratory test results**
☑ **Employment Information** ☑ **Criminal History** ☑ **Family Information**

☑ **Aftercare recommendations** ☑ **Discharge planning** ☑ **Discharge summary**

Other:

Purpose

☐ Continuity of treatment - Patient history - Case Management services ☐ General Updates
☐ Emergency contact
☐ Court services - Legal purposes - Probation - Disability claiming - Unemployment claiming - Employment continuity
☐ Payment related issues

Other:

Expiration
Unless sooner revoked, this consent is valid for **12 months** due to the need for ongoing communication for thecoordination of treatment, or at termination of treatment.

Conditions
I understand that Pine Tree Recovery Center will not condition my treatment on whether I give authorization for therequested disclosure. The consequences of refusing to sign this authorization have been explained to me.

Form of Disclosure
Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem to be appropriate and consistent with applicable law, including but not limited to verbally, in paper format, or electronically.

RE-DISCLOSURE

"This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information in NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse Client."
I may request a copy of this authorization for my records.

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2). Published August 10. 1987, and the Heath Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug and alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. (Under the Mental Heath Code, release of mental health records must be germane to the purpose and need for disclosure).

RIGHT TO REVOCATION

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Pine Tree Recovery Center. I further understand that a revocation of the authorization is not effective to the extent that actionhas been taken in reliance on the authorization.

Client Signature:

Date:

28-December-2022

Teen Challenge Southeast Region

Testing Line 1,
Columbus Eastern, 31902

AIDS / HIV Education

Name: Nine Nine

I received the attached educational materials on AIDS / HIV and understand that I may direct all related questions to mytherapist or medical provider.
In addition, I understand the packet from the Center for Disease Control (CDC) contains additionaldetails.

Notes:
☐ None

NOTICE OF UNIVERSAL PRECAUTIONS FOR INFECTION CONTROL

Universal Precautions refer to the usual and ordinary steps you need to take in order to reduce the risk of infectious disease such as HIV or Hepatitis C. Please carefully read the information enclosed herein and acknowledge your receipt and understanding of the information provided.

Education on Universal Precautions for Infection Control:

The prevention of transmission of infectious diseases is based on the avoidance of skin and mucous membrane contact with blood and other body fluids. Additional training and education may be provided by an appropriate staff member if required.

Avoid Unnecessary Risks:

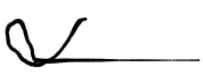
1. If a fellow patient or client needs assistance, please call a staff member immediately. When avoidable, do not expose yourself to other people's blood or body fluids.
2. 2. Never share needles, razors, or any other personal sharp objects such as hair cutting equipment.
3. Always call on trained individuals to clean up blood or other body fluid spills.

Protect Yourself:

1. Utilize hand sanitizer which is available at different areas throughout the treatment area.
2. Use barrier protection to prevent skin and mucous membrane contact with blood and other body fluids.
3. Wear gloves to prevent contact with blood, infectious materials, or other potentially contaminated surfaces or items.
4. Wash hands and skin immediately and thoroughly if contaminated with blood or body fluids. Wash hands immediately after gloves are removed.
5. Use care when handling sharp instruments and needles. Place used sharps in labeled, puncture resistant containers. If you have sustained an exposure or puncture wound, immediately flush the exposed area, and notify a staff member.

Counselor Signature:

Signed by Narendar Nari, Developer on 05-Dec-2022 9:17pm



Supervisor Signature:

Signed by Punit Pawar, punitpawar77 on 01-Feb-2023 12:42pm

(Page 1 is in English, Page 2 is in Spanish)

July 2020

HIV TESTING 101

Many HIV tests are now quick, FREE, and painless.

SHOULD I GET TESTED FOR HIV?

- Everyone aged 13 to 64 should get tested for HIV at least once.
- You should get tested at least once a year if you continue to engage in any of the following behaviors:
  - You're a man who has had sex with another man.
  - You've had sex with a partner who has HIV.
  - You've had more than one partner since your last HIV test.
  - You've shared needles, syringes, or other equipment to inject drugs.
  - You've exchanged sex for drugs or money.
  - You have another sexually transmitted disease, hepatitis, or tuberculosis.
  - You've had sex with anyone who has done anything listed above or with someone whose sexual history you don't know.
- Sexually active gay and bisexual men may benefit from testing every 3 to 6 months.
- If you're pregnant or planning to get pregnant, get tested as early as possible to protect yourself and your baby.

WHERE CAN I GET TESTED?

Ask your health care provider for an HIV test, or find a testing site near you by
- visiting **gettested.cdc.gov**, or
- calling **1-800-CDC-INFO (232-4636)**.

Many testing locations are FREE and confidential. You can also buy an HIV self-test at a pharmacy or online. Most HIV tests are covered by health insurance.

WHAT IF MY TEST RESULT IS NEGATIVE?

- You probably don't have HIV, but the accuracy of your result depends on the *window period*. This is the time between when you may have been exposed to HIV and when a test is able to show if you have the virus or not.
- To stay negative, take actions to prevent HIV. Visit **www.cdc.gov/hiv/basics/prevention.html** to learn more.

WHAT IF MY TEST RESULT IS POSITIVE?

- You may be given a follow-up test to confirm the result.
- If you're diagnosed with HIV, start treatment right away. HIV treatment can keep you healthy for many years and reduce your chance of transmitting the virus to others. Learn more at **www.cdc.gov/hiv/basics/livingwithhiv**.

For more information please visit **www.cdc.gov/hiv**

(Page 1 is in English, Page 2 is in Spanish)

July 2020

HIV 101

Without treatment, HIV (human immunodeficiency virus) can make a person very sick and even cause death. Learning the basics about HIV can keep you healthy and prevent transmission.

HIV CAN BE TRANSMITTED BY

Sexual Contact

Sharing Needles to Inject Drugs

Mother to Baby During Pregnancy, Birth, or Breastfeeding

HIV IS NOT TRANSMITTED BY

Air or Water

Saliva, Sweat, Tears, or Closed-Mouth Kissing

Insects or Pets

Sharing Toilets, Food, or Drinks

PROTECT YOURSELF FROM HIV

- Get tested at least once or more often if you are at risk.
- Use condoms the right way every time you have anal or vaginal sex.
- Choose activities with little to no risk like oral sex.
- Don't inject drugs, or if you do, don't share needles, syringes, or other drug injection equipment.

- If you are at risk for HIV, ask your health care provider if pre-exposure prophylaxis (PrEP) is right for you.
- If you think you've been exposed to HIV within the last 3 days, ask a health care provider about post-exposure prophylaxis (PEP) right away. PEP can prevent HIV, but it must be started within 72 hours.
- Get tested and treated for other STDs.

KEEP YOURSELF HEALTHY AND PROTECT OTHERS IF YOU HAVE HIV

- Find HIV care. It can keep you healthy and help reduce the risk of transmitting HIV to others.
- Take your HIV medicine as prescribed.
- Stay in HIV care.

- Tell your sex or injection partners that you have HIV. Use condoms the right way every time you have sex, and talk to your partners about PrEP.
- Get tested and treated for other STDs.

For more information please visit **www.cdc.gov/hiv**

HIV CONSULTATION AND REFERRAL SERVICES

September 2020

CDC-INFO

CDC's national health information hotline, providing answers to your questions regarding HIV, how to protect yourself, and where to get an HIV test.
1-800-CDC-INFO (232-4636) | 1-888-232-6348 TTY
In English, en Español, 8 am to 8 pm EST, Monday through Friday
www.cdc.gov/info

HIVInfo

A service of the United States Department of Health and Human Services (HHS), offers access to the latest, federally approved HIV/AIDS medical practice guidelines, HIV treatment and prevention clinical trials, and other research information for health care providers, researchers, people affected by HIV/AIDS, and the general public.
1-800-HIV-0440 (448-0440) | 1-888-480-3739 TTY
1-301-315-2816 (Outside the US)
In English, en Español, 1 pm to 4 pm EST, Monday through Friday
ContactUs@HIVinfo.NIH.gov | hivinfo.nih.gov

The Clinician Consultation Center

http://nccc.ucsf.edu

Clinicians' Warmline

Provides health care providers with expert clinical advice on preventing and treating HIV.
1-800-933-3413: | 9 am to 8 pm EST, Monday through Friday

Perinatal HIV Hotline

Provides clinicians with around-the-clock advice on indications and interpretations of HIV testing in pregnancy, and consultation on antiretroviral use during pregnancy, labor and delivery, and the postpartum period.
1-888-448-8765 | 24 hours, seven days a week

PEPline

Provides expert guidance in managing health care worker exposures to HIV and hepatitis B and C. Clinicians receive immediate post-exposure prophylaxis (PEP) recommendations.
1-888-448-4911 | Occupational PEP: 11 am to 8 pm EST, seven days a week | **Non-occupational PEP:** 9 am to 8 pm EST, Monday through Friday; 11 am to 8 pm EST, weekends and holidays

PrEPline

Provides expert guidance on considerations for providing pre-exposure prophylaxis (PrEP) to people who don't have HIV as part of an HIV prevention program.
1-855-448-7737 | 9 am to 8 pm EST, Monday through Friday

Substance Use Management

Peer-to-peer consultation from physicians, clinical pharmacists, and nurses with special expertise in substance use evaluation and management.
1-855-300-3595 | 9 am to 8 pm EST, Monday through Friday

For more information please call **1-800-CDC-INFO (232-4636)**
or visit **www.cdc.gov/hiv**