RECOVERY TECHNOLOGY L.L.C.

_____

First Time Appointment Billing Form

Client Name_____ Case #_____Date_____

Clinician Name _____

Assigned Clinician: _____

Location of Intake: ◯ Office ◯ Hospital ◯ Crisis Home

◯ Client Home ◯ Other: _____

OPT: ◯ Planning Session ◯ Assessment

◯ Anger Management/BIP ◯ Other: _____

CSM: Number of Units: _____ Time: _____

LifeWays Community Mental Health
www.lifewayscmh.org

Consent to Participate in Services

IDENTIFYING INFORMATION			
NAME	DOB	CASE #	GENDER
ADDRESS			

DATE

TREATMENT AND PARTICIPATION

I/ my ward/ my child agrees to participate in the services/treatment offered by LifeWays. The services may be provided by LifeWays or LifeWays' provider network. I understand that I will be asked to consent to a treatment plan based on my needs. My treatment plan (we also call this an Individual Plan of Service) will be written by my treatment team, and, if I want, will include input from my family, and/or other support professionals who take part in my care.

I understand that additional consents may be necessary for certain treatment options such as psychotropic medications

I understand that all services/treatments will be explained to my satisfaction including their purpose, risks, benefits, and any appropriate alternatives.

RECEIPT

The following items have been explained to me and I have received a copy of the following:

- Welcome to LifeWays Letter
- Your Rights Booklet
- LifeWays Guide To Services
- LifeWays Notice of Privacy Practices
- Information on Grievances, Appeals, and Second Opinions
- Michigan Advance Directive for Mental Health Care Brochure
- 2-1-1 Brochure
- LifeWays Community Mental Health Services Brochure
- Consumer Responsibilities

NOTIFICATION

I understand that LifeWays is required to coordinate my treatment with medical providers who care for my physical health, specifically my primary care provider.

I understand that when a LifeWays employee/provider has been accidentally exposed to my blood and/or bodily fluids my/ my ward's/ my child's blood may be tested for Hepatitis B and HIV (Aids Virus). I will be told of any positive results unless I/ my ward/ my child cannot be found when the results are received. (in accordance with Michigan Law; PA 488 and LifeWays policy)

I understand that LifeWays is authorized to release non-identifying information on any reportable communicable disease, infection, and/or condition to the Michigan Department of Health and Human Services in accordance with the Michigan Mental Health Code Public Act 258 of 1974, Section 748, Rule 330.1748 Confidentiality.

FOLLOW-UP

I understand LifeWays may contact me for purposes of obtaining follow up information concerning my satisfaction and progress since receiving services. This information is used internally for quality improvement purposes and to determine if services have been effective. All information is protected by LifeWays and its representatives to ensure confidentiality.

VALID

I understand that I may withdraw my consent and participation at any time without penalty.

I understand that I may revoke at any time except to the extent that action has been taken in reliance on it.

This consent shall no longer be valid one year from the date of this form. Any forms signed after the date on this form shall replace this form and be considered the most current consent.

Upon request, I may receive a copy of this consent

SIGNATURES

My signature acknowledges my understanding that I am agreeing to participate in services at LifeWays and/or one of LifeWays network provider agencies.

SIGNATURES

STAFF SIGNATURE / CREDENTIALS _____ DATE _____

CONSUMER / PARENT / GUARDIAN SIGNATURE _____ PRINTED NAME _____ DATE _____

Note: A new consent form must be obtained if: legally competent minor reaches his/her 18th birthday; or c) change of guardianship status.

*Witness is responsible to, in good faith, assure that if the consumer signs, she/he was competent to give informed consent (R330.7003) (R300.6013) (a)-(c) Michigan Department of Community Health emergency rules, or if guardian signed, documentation is on file indicating that the court has empowered the guardian with the authority. If the witness does not feel the consumer is competent, refer to R330.6011 (3)-(4)

Testing for HBV/HIV without consent would not be for routine testing, rather for testing after unexpected staff contact with bodily fluid. 333.5133.10b "The HIV test is performed after a health professional, health facility employee, police officer, or fire fighter, or a medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic licensed under section 20950 or 20952 sustains in the health facility, while treating the patient before transport to the health facility, or while transporting the patient to the health facility, a percutaneous, mucous membrane, or open wound exposure to the blood or other body fluids of the patient."

Tele-mental Health Informed Consent

I, _____, hereby consent to participate in tele-mental health with, _____, as part of my treatment. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to tele-mental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risks, benefits, and consequences associated with tele-mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate, and a higher level of care required.
6) I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to reschedule.
7) I understand that my clinician/staff may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my clinician/staff. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of clinician/staff Date:

_____

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name_____ Case #_____Date_____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Recovery Technology's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Recipient Rights Officer Andra Antczak at (517) 796-4520.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Personal Representative: _____ Date: _____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

☐ Consumer/Patient Refuses to Acknowledge Receipt:

Signature of Staff Person: _____ Date: _____

Consent to Share Behavioral Health Information

Use this form to give or take away your consent to share information about your:

- Mental and behavioral health services. This will be referred to as "behavioral health" throughout the form.
- Diagnosis, referral, and treatment for an alcohol or substance use disorder. This will be referred to as "substance use disorder" throughout this form.

This information will be shared to help diagnose, treat, manage, and pay for your health needs.

Why This Form is Needed

When you receive health care, your health care provider and health plan keep records about your health and the services you receive. This information becomes a part of your medical record. Under state and federal laws, your health care provider and health plan do not need your consent to share most types of your health information to treat you, coordinate your care, or get paid for your care. But they may need your consent to share your behavioral health or substance use disorder records.

Instructions

- To **give** consent, fill out Sections 1, 2, 3, and 4.
- To **take** away consent, fill out Sections 5.
- Sign the completed form, then give it to your health care provider. They can make a copy for you.

SECTION 1: ABOUT YOU

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH	DATE SIGNED

SECTION 2: WHO CAN SEE YOUR INFORMATION AND HOW THEY CAN SHARE IT

SECTION 2A: SHARING INFORMATION BETWEEN INDIVIDUALS AND ORGANIZATIONS

Let us know who can see and share your behavioral health and substance use disorder records. You should list the specific names of health care providers, health plans, family members, or others. They can only share your records with people or organizations listed below.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

SECTION 2B: SHARING INFORMATION ELECTRONICALLY

Health information exchanges or networks share records back and forth electronically. This type of sharing helps the people involved in your health care. It helps them provide better, faster, safer, and more complete care for you. Your health care provider and health plan may have already listed these organizations below.

CHOOSE ONLY ONE OPTION:

☐ Share my information through the organizations listed below. This information will be shared with the individuals and organizations listed under Section 2a

☐ Do not share my information through the organizations listed below.

☐ Share my information through the organizations listed below with all of my past, current, and future treating providers. If I choose this option, I can request a list of providers who have seen my records.

☐ PCE Systems

☐ Michigan Health Information Network

SECTION 3: WHAT INFORMATION YOU WANT TO SHARE

CHOOSE ONE OPTION:

☐ Share **all** of my behavioral health and substance use disorder records. This does not include "psychotherapy notes."

☐ Share **only** the types of behavioral health and substance use disorder records listed below. For example, what I am being treated for, my medications, lab results, etc.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

SECTION 4: YOUR CONSENT AND SIGNATURE

Read the statements below, then sign and date the form.

By signing this form, I understand:

- I am giving consent to share my behavioral health and substance use disorder records. This includes referrals and services for alcohol and substance use disorders, but other information may also be shared.
- I do not have to fill out this form. If I do not fill it out, I can still get treatment, health insurance or benefits. But, without this form, my provider or health plan may not have all the information needed to treat me.
- My records listed above in Section 3 will be shared to help diagnose, treat, manage, and pay for my health needs.
- My records may be shared with the people or organizations as stated in Section 2.
- Other types of my information may be shared along with my behavioral health and substance use disorder records. Under existing laws, my health care provider and health plan do not need my consent to share most types of my health information to treat me, coordinate my care or get paid for care.
- This form does not give my consent to share "psychotherapy notes".
- I can remove my consent to share behavioral health and substance use disorder records at any time. I understand that any records already shared because of past approval cannot be taken back. I should tell all individuals and organizations listed on this form if I remove my consent.
- I have read this form. Or it has been read to me in a language I can understand. My questions about this form have been answered. I can have a copy of this form.
- This signature is good for **1 year** from the date signed. Or I can choose an earlier date or have it after the event or condition listed below. (For example, at the end of my treatment.)

Date, event, or condition:

CONSUMER SIGNATURE	PRINTED NAME	DATE
PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE SIGNATURE	PRINTED NAME	DATE
WITNESS SIGNATURE	PRINTED NAME	DATE

TAKE AWAY YOUR CONSENT

Complete Section 5 if you no longer want to share your records listed above in Section 3.

SECTION 5: WHO CAN NO LONGER SEE YOUR INFORMATION

I no longer want to share my records with those listed in Sections 2a and 2b. I understand any information already shared because of past approval cannot be taken back.

State your relationship to the person withdrawing consent, then sign and date below.

☐ Self
☐ Parent (Print Name)
☐ Guardian (Print Name)
☐ Authorized Representative (Print Name)

SIGNATURE _____ DATE _____

WITNESS SIGNATURE (IF APPROPRIATE) _____ DATE _____

FOR HEALTH CARE PROVIDER OR HEALTH PLAN USE ONLY

VERBAL WITHDRAW OF CONSENT

☐ The individual listed above in Section 1 has taken away his/her consent.

List the individual who requested the withdrawal below, then sign and date below.

☐ Individual listed in Section 1
☐ Parent (Print Name)
☐ Guardian (Print Name)
☐ Authorized Representative (Print Name)

SIGNATURE OF PERSON RECEIVING VERBAL WITHDRAW OF CONSENT _____ DATE _____

Other Information for Health Care Providers and Health Plans

This form cannot be used for a release of information from any person or agency that has provided services for domestic violence, sexual assault, stalking, or other crimes. See the FAQ for providers and other organizations at michigan.gov/bhconsent

Additional Identifiers (Optional)

MEDICAID LAST 4 OF THE SOCIAL SECURITY NUMBER CASE #

Form Copy (Optional, Choose One Option)

☐ The individual in Section 1 **received** a copy of this form.
☐ The individual in Section 1 **declined** a copy of this form.

AUTHORITY:	This form is acceptable to the Michigan Department of Health and Human Services (MDHHS) as compliant with 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq and PA 129 of 2014, MCL 330.1141a.
COMPLETION:	Is Voluntary, but required if disclosure is requested.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

MDHHS-5515 (12-18) Previous edition obsolete.

HENRY FORD HEALTH℠

AUTHORIZATION TO ACCESS or RELEASE MEDICAL INFORMATION

COGNITIVE PATIENT LABEL

Questions: Contact Medical Records: 313.916.4540
Please mail completed form to: Medical Records 1414 E. Maple Road, Troy, MI 48083 (**Mailing Address ONLY)**
or Medical Records email address: HFHSMedicalRecords@hfhs.org • fax number 313.916.3917
(Please keep in mind that emails sent over the internet may not be secure.)

Patient Information (please print)

Name (First, Middle, Last)		Maiden name or previous names	
Address	City	State	Zip Code
Date of Birth	Phone	E-mail Address if Applicable	

I authorize my records to be sent from:

Henry Ford Health:

- ☐ HF Jackson
- ☐ HF Jackson Specialty Hospital
- ☐ HF Behavioral Health
- ☐ HF Hospital Detroit
- ☐ HF Kingswood Hospital
- ☐ HF Macomb Hospital
- ☐ HF Maplegrove Center
- ☐ HF West Bloomfield Hospital
- ☐ HF Wyandotte Hospital
- ☐ HF Other (Clinic/Medical Center): _____

Other Facility:

Name/Organization			
Address	City	State	Zip Code

I authorize my records to be released to:

Myself: (Select only one option)

- ☐ MyChart patient portal (patient request)
- ☐ E-mail to me at address above
- ☐ Mailed to me at address above
- ☐ On site inspection. (Authorization is valid only if received by Henry Ford Health System within 60 days of the date signed.)
- ☐ Mailed to address below
- ☐ Faxed to number below

Other: Disclose to - complete information below

Name/Organization Recovery Technology			
Address 1200 N. West Ave, Suite 400	City Jackson	State MI	Zip Code 49202
Phone Number 517-780-3336	Fax Number 517-796-4561		

Please complete below if you want to include medical records for these services:

☐ Substance Use Disorder diagnosis and treatment

Purpose: ☐ Continuation of Care ☐ Legal ☐ Personal ☐ Other _____

☐ Psychotherapy Notes

Specific Information Requested:

Type of Record requested		Date of Service	Type of Record Requested		Date of Service
	Discharge Summary			Outpatient Record	
	Emergency Department			Radiology Report	
	Laboratory Report			Office Note	
	Immunizations			Other:_____	
	Inpatient Record			_____	

By signing this authorization, I hereby authorize Henry Ford Health System to disclose information contained in the medical record of the patient identified above, which includes information that may be stored in a paper and/or electronic format, as set forth below. Such notes may contain information on: general medical care, psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC), as applicable; communicable diseases or infections, including sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis, as applicable; demographic information; and treatment received by other health care providers. Any alcohol and substance use disorder information disclosed to you in these records is protected by Federal confidentiality rules (42 CFR Part 2). 42 CFR Part 2 prohibits unauthorized disclosure of these records. Patient access fee may apply for copies. Fees are authorized annually by the State of Michigan Medical Records Access Act, P.A. 47 of 2004, MCL 333.26269.

I understand that:

- I may revoke (take back) this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released prior to receiving the revocation. Contact Henry Ford Health System Medical Records department. Contact information is available at the top of the form.
- This authorization expires when the patient information is disclosed as permitted in this authorization, or within one (1) year from the date that it is signed unless another expiration date is written here: _____ _____ (describe the date/event/condition upon which authorization will expire, which must be no longer than one year from the date signed)
- My care or treatment will not be conditioned on signing this authorization
- The person(s) to whom information is disclosed under this authorization may possibly redisclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.
- Henry Ford Health System and/or its copying service reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.

Signature_____Relationship (if other than patient) _____

Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA. (if legal guardian, Personal Presentative or person of authority under a durable medical power of attorney, a copy of appropriate documentation may be required)

Date_____ Time_____

LifeWays
Community Mental Health

Authorization to Exchange Information between LifeWays CMH and MDHHS (Michigan Department of Health and Human Services)

Instructions on completing this Health Insurance Portability and Accountability Act of 1996 (HIPAA) form:

1. All areas should be complete
2. This form must be signed and dated by the patient or guardian.
3. This form can be faxed to 517-796-4532 or returned to the LifeWays Network Benefits Team

Patient First Name:	Patient Last Name:	Date of Birth:

Patient Address (street, city, zip):

Guardian Name: Check if Not Applicable ☐

This authorization will be valid for a period of ONE YEAR From the signed date, unless a lesser time frame is indicated: Alternative Expiration Date:	Authorized provider, LifeWays Community Mental Health, 1200 N. West Ave, Jackson, MI 49202 to exchange the information identified below to and from: Michigan Department of Health and Human Services

I, or my guardian, request that information regarding federal/state program benefit determination and contact information including- but not limited to- first name, last name, phone number, and address be exchanged to LifeWays Community Mental Health for purpose of any state/federal benefits (cash, food, Medical).

I understand that:

1. Protected health information may include information and records protected under federal and state law such as benefit determination and first name, last name, phone number, and address.
2. My treatment, payment or eligibility of benefits may not be conditioned on signing this authorization.
3. I understand that I may revoke this authorization at any time by writing to LifeWays, Attn: Customer Services, 1200 N. West Ave. Jackson, MI 49202, except to the extent that LifeWays has taken action in reliance to the authorization.
4. It is recommended I retain a copy of this signed form for my records, understanding that a copy is as valid as the original.

_____ _____

Signature of Claimant/Consumer, Guardian or Authorized Representative — Date

_____ _____

Printed Name of Claimant/Consumer, Guardian or Authorized Representative — Date

RECOVERY TECHNOLOGY L.L.C.

Primary Physician Coordination of Care Form

Doctor: _____ Date: _____

Address: _____

City/State/Zip: _____

Re: _____ DOB _____

Dear Dr. _____

This is to inform you that the above-named patient has had the following change in treatment:

☐ Hospitalization ☐ Crisis Home Placement ☐ Other: _____

Receiving the following services:

☐ Outpatient Mental Health Therapy
☐ Substance Abuse Therapy
☐ Assertive Community Treatment
☐ Integrated Dual Disorder Treatment
☐ Dialectical Behavior Therapy
☐ Case Management

Request information from you:

☐ Most current lab results
☐ Diagnosis that you are treating
☐ Most recent physical exam results
☐ Immunization Records
☐ Medications being prescribed by you
☐ Other: _____

The Patient's Diagnosis is: _____

_____

_____

_____

☐ THIS PERSON QUALIFIES AS A MEDICALLY INDIGENT INDIVIDUAL AS DEFINED IN SECTION 106 OF THE SOCIAL WELFARE ACT." MCL § 333.26263(K)

THE SOCIAL WELFARE ACT DEFINES A "MEDICALLY INDIGENT INDIVIDUAL" AS "[A]N INDIVIDUAL RECEIVING FAMILY INDEPENDENCE PROGRAM BENEFITS OR AN INDIVIDUAL RECEIVING SUPPLEMENTAL SECURITY INCOME . . ."

MICHIGAN'S MEDICAL RECORDS ACCESS ACT, PROVIDES THAT "A HEALTH CARE PROVIDER, HEALTH FACILITY, OR MEDICAL RECORDS COMPANY SHALL WAIVE ALL FEES FOR A MEDICALLY INDIGENT INDIVIDUAL." MCL § 333.26269(E)(3).

The patient has signed a release allowing further contact between us. Please feel free to contact me for any questions or coordination of care.

Clinician: _____ Phone Number: _____
(please print)

Clinician Signature/Credentials: _____

Choice of Provider

Date: _____

Client Name: _____ **Case #** _____

Outpatient Therapy: _____ ☐ **Not Applicable**

Case Management: _____ ☐ **Not Applicable**

Assertive Community Treatment: _____ ☐ **Not Applicable**

Outpatient Psychiatric Services: _____ ☐ **Not Applicable**

Other: _____

Other: _____

Other: _____

I attest that I have been given a choice of provider for services.

_____ **Date:** _____

Client/Guardian

Service Orientation Checklist

Client Name: _____ Case #: _____

Please check all that apply:

I have chosen the following service(s):

- ☐ Individual Therapy
- ☐ Case Management
- ☐ Anger Management
- ☐ Dialectical Behavior Therapy
- ☐ Assertive Community Treatment
- ☐ Integrated Dual Diagnosis Treatment
- ☐ Psychiatric
- ☐ Other

- ☐ I have been educated on the service I have chosen and had a chance to ask questions.
- ☐ I have been informed that the Internal Recipient Rights Advisor for Recovery Technology is Andra Antczak at 796-4520.
- ☐ I was trained on the emergency preparedness plan (fire, tornados, bomb threats, assaults with weapons, aggressive behaviors and how to use the fire extinguishers and emergency exits.)
- ☐ Self-determination was explained to me and I was given the choice to participate or not.
- ☐ Quality Improvement was explained to me and I was invited to be a member of the Advisory Board Committee (ABC).
- ☐ Clinician discussed with me the importance of keeping appointments and participating in services scheduled. **I understand that if I miss 3 appointments I may be discharged from the service.**
- ☐ Treatment is court ordered and the requirements for follow-up and discharge have been explained to me.

_____ _____ _____ _____

Client Signature Date Witness Date

_____ _____

Guardian Signature Date

Informal Complaint Process

Date: _____

Client Name: _____ Case #: _____

If you have any questions or concerns regarding your services at Recovery Technology, please call one of the following phone numbers for assistance. If you are unhappy with the outcome of your informal complaint, please contact a member of Recover Technology's management team or if referred by LifeWays, you may contact LifeWays Customer Service.

For Recovery Technology:

Clinician's Name:_____	Phone: _____
Recovery Technology Receptionist	517-780-3336
Recovery Technology CEO/Management	517-780-3336
Recovery Technology Recipient Rights Advisor	517-796-4520

If referred by LifeWays:

LifeWays Customer Service	517-780-3332

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Communication and Message Consent Form

Client Name: _____ Case #: _____ Date: _____

We, at RECOVERY TECHNOLOGY LLC, are committed to safeguarding the privacy and confidentiality of your records including the personal information that you provide us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

From time to time, it may be necessary or desirable to contact patients by phone **or text**. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

- ☐ I **DO NOT** want to have detailed messages left with another person who could answer my phone.
- ☐ I **DO NOT** want to have detailed messages left on my voicemail.
- ☐ I **DO NOT** want to be texted with appointment reminders.
- ☐ I **DO NOT** want to receive phone calls with appointment reminders.
- ☐ I **DO NOT** want to receive phone calls at my place of employment.

TEXT MESSAGING INFORMATION

How we will use text messaging: We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your text messages may be forwarded to another RECOVERY TECHNOLOGY LLC staff member as necessary for appropriate handling. We will not disclose your text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted use of your health information and your rights regarding privacy matters.

Risk of using text messages: The use of text messages has a few risks that you should consider. These risks include, but are not limited to, the following:

- Texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress a text and send the information to an undesired recipient.
- Employers and on-line services have a right to inspect texts sent through their company systems.
- Texts can be intercepted, altered, forwarded or used without authorization or detection.
- Texts can be used as evidence in court.
- Text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

Conditions for the use of text messages:

RECOVERY TECHNOLOGY, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of text information sent and received. You must acknowledge and consent to the following conditions (by signing below):

- **IN A MEDICAL EMERGENCY, DO NOT USE TEXTING, CALL 911.**
- If you have an urgent problem during regular business hours, please call your case manager or outpatient therapist, or 517-780-3336. Urgent messages or needs should be relayed to us by using regular telephone communication.
- You should speak with your case manager or therapist to discuss complex and/or sensitive situations rather than using text messages regarding such situations.

- Text messages may be filed electronically into your medical record.
- Clinical staff will not forward your identifiable texts to outside parties without your written consent, except as authorized by law.
- You should use your best judgment when considering the use of text messages for communication of sensitive medical information. **Clinical staff are not responsible for the content of messages.**
- RECOVERY TECHNOLOGY, LLC is not liable for breaches of confidentiality caused by you or any third party.
- It is your responsibility to follow up with staff if warranted.

I UNDERSTAND THAT STANDARD CELL PHONE RATES AND TEXT MESSAGING RATES WILL APPLY TO ANY MESSAGE RECEIVED FROM RECOVERY TECHNOLOGY. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME. MY REVOCATION OF CONSENT WILL NOT AFFECT MY ABILITY TO OBTAIN FUTURE HEALTH CARE NOR WILL IT CAUSE THE LOSS OF ANY BENEFITS TO WHICH I AM OTHERWISE ENTITLED.

THIS CONSENT DOES NOT EXPIRE UNLESS SPECIFICALLY REVOKED BY THE CLIENT/GUARDIAN.

Client/Guardian Signature: _____

Date

Witness Signature: _____

Date

CIRCLE OF SUPPORTS