I CARE PSYCH
CONSENT TO TREATMENT & DISCLOSURE OF INFORMATION

As the patient or legal guardian with the authority to consent on behalf of the patient named below (collectively hereinafter referred to as the "Patient"), I hereby consent for the Patient to receive medical treatment at I Care Psych, LLC and Comprehensive Addiction and Recovery Epicenter, LLC and their employed and/or contracted providers (collectively "I Care Psych"). My signature below hereby confirms my consent for I Care Psych to provide health care services and prescribe/administer medicinal drugs to the Patient as described herein. This consent includes, without limitation, consent for the Patient to be evaluated, diagnosed, and treated for medical conditions (including but not limited to physical and mental health conditions, psychiatric care and counseling, substance use disorder diagnosis and treatment, or other sensitive conditions if applicable to the Patient), as deemed necessary and advisable in the judgment of the Patient's treating providers.

TREATMENT SERVICES. I understand that the rendering of medical care is not an exact science and no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments, medications, therapy, or other healthcare services provided or recommended by I Care Psych. Treatment services provided to the Patient may consist of the following outpatient services, without limitation and where applicable to the Patient: ordinary and necessary medical and psychiatric treatment and examinations consisting of physical exams, counseling, psychotherapy, psychiatric care, mental health evaluations, psychological assessments, medication assisted treatment and substance use disorder treatment. I understand and agree that this may include the administration and/or prescribing of medications, potentially including controlled substances and psychotropic medications, used in the course of ordinary and necessary medical, substance use disorder, and psychiatric care (if applicable to the Patient). I acknowledge that I have the right to refuse any and all treatment services and medications. All treatment services provided by I Care Psych are on an outpatient basis only. I understand that I Care Psych is not an emergency response unit or inpatient facility. By signing below, **I agree to call 911 or go immediately to an emergency room for any emergency medical event or a situation that could reasonably be expected to develop into an emergency**.

MEDICATIONS. I agree to inform my treating providers of medications taken and/or prescribed to the Patient. Medications should be used only as directed. All medications have side effects. If the Patient experiences side effects or any unusual feelings as a result of medication prescribed during the course of treatment, I agree to contact the office without delay and inform the Patient's provider. If the concern is severe enough, is an emergency, or is a situation that could possibly develop into an emergency, I agree to immediately dial 911 or go to the nearest emergency room and follow the directions of emergency personnel. I understand that alternative treatments may be available that do not involve medications. I agree to ask my provider if I have any questions related to alternative treatments, the risks associated with not treating a problem or condition, as well as the risks involved in any specific medication.

CONSENT TO OFF-LABEL USE. Once a medication is approved by the U.S. Food and Drug Administration ("FDA"), the manufacturer produces a "label" to explain its use. Health care providers may use or recommend such medication for other purposes (referred to as "off-label") if the health care provider is well-informed about the medication, bases its use on firm scientific method and sound medical evidence, and maintains records of its use and effects. Medications recommended during the course of treatment at I Care Psych may be for a use that is not specified in the FDA approved labeling. By signing below, I acknowledge my understanding that medications recommended to the Patient during the course of treatment may be prescribed for a use that is not specified in the FDA approved labeling for which it is being used, but rather, may be recommended for an off-label use based on the professional judgment of the treating provider. I acknowledge that the risks associated with medications prescribed and any off-label use have

been explained and agree to address any concerns I have about off-label medication use with the Patient's provider.

CONFIDENTIALITY. I Care Psych is dedicated to maintaining the privacy of health and other sensitive information in accordance with applicable law. Patient information, including any substance use disorder diagnosis or treatment information if applicable, will be held confidential in accordance with applicable law unless a legal exception applies, or I consent to the disclosure. For any such disclosures, I Care Psych will limit the information disclosed to that which is necessary to carry out the purpose of the disclosure. Generally, I Care Psych will not acknowledge that the Patient is a substance use disorder patient without consent or a valid court order, unless an exception under the law applies. More details about how patient information may be used or disclosed is included in the Notice of Privacy Practices. I further understand that if I am seeking treatment for services other than substance use disorders, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") shall apply to my health information but may not be as protective as substance use disorder confidentiality laws. By signing below, I confirm that I received a copy of the I Care Psych Notice of Privacy Practices and understand that I can request more information about my privacy rights at any time.

DISCLOSURE FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I specifically authorize I Care Psych to obtain, use, and/or disclose the Patient's health information as necessary to provide treatment to the Patient, process and receive payments related to the Patient's treatment, and for health care operations in accordance with applicable law. This specifically includes authorization to disclose the Patient's health information (including without limitation complete psychological and assessment records, treatment plans, progress summaries, treatment notes, diagnosis, mental health information, HIV/AIDS and/or other STD information, substance use disorder diagnosis and treatment information, genetic information, and related documents and information) to other treating providers, health plans, third-party payers, and third parties that assist with the operation of I Care Psych (business associates that have agreed in writing to protect the privacy of information). Whenever necessary, I specifically authorize I Care Psych to consult with other physicians or specialists as needed to provide the Patient with treatment services and to disclose the Patient's information as described in this form for such purposes. I understand that I may revoke this consent to disclose the Patient's information at any time except to the extent I Care Psych has acted in reliance on it and that this consent will remain in effect until I revoke it. Records used or disclosed pursuant to this consent may be subject to redisclosure by the recipient and no longer protected by substance use disorder privacy laws. If the Patient is receiving substance use disorder treatment at I Care Psych, I acknowledge that the disclosure of the Patient's information as authorized herein may result in redisclosure in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), except for any use and disclosure of substance use disorder information for civil, criminal, administrative, and legislative proceedings against the Patient.

COMMUNICATIONS ABOUT MY TREATMENT. I agree that by providing my landline, cell phone number(s) or email address, I am giving express consent for I Care Psych, its staff, employees, independent contractors, assignees, successors, and agents, to contact me at these numbers and email addresses, or any number or email address that is later acquired for me and to leave live or pre-recorded messages, voicemails, or text messages regarding my healthcare diagnosis and treatment, appointment reminders, my account, or my bill related to any services I receive. I understand and agree that I am responsible for any charges from my telecommunications provider related to such communications, and that using any unsecure electronic communication (such as regular email or standard text messaging) or shared accounts to communicate can present risks to the privacy and security of information. These risks include possible interception of the information by unauthorized parties, misdirected emails, message forwarding, or storage of the information on unsecured platforms and/or devices. I accept these risks and confirm that any phone number I provide is associated with me and not a third-party. For greater efficiency, calls may be delivered by an auto-dialer. Providing a telephone or cell phone number is not a condition of receiving services. I understand I may opt

out of text messaging at any time by following the opt-out instructions in the message I receive or by contacting I Care Psych directly, and systems may take time to update after I submit my request. I Care Psych will not share mobile opt-in information for text messaging with third parties for their marketing purposes, nor will I Care Psych sell or use opt-in contact information for any other unauthorized purposes.

DISCLOSURE TO PRESCRIPTION DRUG MONITORING PROGRAM. The State of Florida has a prescription drug monitoring program ("PDMP") in place to monitor the prescribing and dispensing of controlled medications. In accordance with Florida law, where applicable, I consent to I Care Psych providers accessing and/or disclosing health information, including substance use information, for the purpose of accessing and maintaining the PDMP database and providing treatment services to the Patient (including coordination of care).

NO SHOW/MISSED APPOINTMENT POLICY & NO-SHOW FEE. I understand that unless prohibited by my insurance contract or applicable law, I Care Psych requires **at least 24 hours prior notice if I need to cancel or change the Patient's appointment time**. I Care Psych may charge a fee of $75.00 for standard appointments and $125.00 for initial appointments (the "No Show Fee") for missing or cancelling initial or follow-up appointments if I fail to provide such advanced notice. I acknowledge a No-Show Fee is my responsibility and must be paid prior to scheduling and being seen at another appointment. This policy applies to, and is the same amount, for all patients when collection of a No Show Fee is permissible by the third-party payor (where applicable). I agree that No-Show Fees are not payable by my insurance and that I will be personally responsible for paying the No-Show Fee directly to I Care Psych. I specifically authorize I Care Psych to process payment of No-Show Fees as specified herein on my payment card and confirm that I am an authorized user of each payment card I provide to I Care Psych. If I have three or more instances where I fail to provide at least 24 hours prior notice of cancellation, I understand that I Care Psych may terminate its treatment relationship with me.

TELEMEDICINE CONSENT. I understand that I Care Psych may provide an opportunity to receive some services through telemedicine encounters and by signing this form I agree to receive services by telemedicine. Telemedicine provides many benefits, such as convenience, but also carries certain risks. Receiving treatment via telemedicine means that I Care Psych will not be meeting with the Patient in person for the telemedicine encounter and that the Patient's provider will communicate with the use of synchronous or asynchronous telecommunications technology. Unless restricted by law, or in the discretion of the Patient's provider, I Care Psych providers may diagnose, treat, and consult with me about the Patient's health via telecommunications technology. I acknowledge and agree to the following related to being treated via telemedicine: (a) I Care Psych cannot guarantee the privacy of patient information if I utilize telemedicine in places or on devices where other individuals may be able to access, intercept, or overhear the information; (b) telemedicine may not be appropriate in all cases and has certain limitations; (c) I Care Psych and its providers are licensed in Florida, and I confirm I am (and will be) located in Florida at the time of each telemedicine encounter; (d) I am responsible for providing I Care Psych with my medical history, records, and any other information important for the Patient's provider to know in order to provide the Patient with appropriate treatment; and (e) certain health conditions or assessments may require an in-person exam, in which case I Care Psych may require me to schedule an in-person appointment. **In the event of a medical emergency, I understand I should immediately dial 911. Telemedicine services are not intended for use in the event of a medical emergency**. I authorize the I Care Psych to provide the Patient's diagnosis, observations, and recommendations regarding the Patient's condition through telemedicine or over the phone. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of the Patient's care at any time, without affecting the Patient's right to future care or treatment.

ASSIGNMENT OF BENEFITS. I hereby authorize direct payment of medical benefits to I Care Psych for services rendered by I Care Psych and its providers. I understand that I am financially responsible for

any balance not covered by the Patient's insurance. I request that payment of authorized benefits be made directly to I Care Psych on my behalf and authorize the use and disclosure of the Patient's health information (including mental health information and diagnosis, HIV/AIDS and/or other STD information, substance use disorder diagnosis and treatment information, and genetic information) as needed to facilitate payment for the services provided.

I further acknowledge that:

- I Care Psych will be required to send the Patient's medical information to my insurance company when services are billed to insurance.
- I have the right to refuse any procedure or treatment and to discuss all medical treatments with my provider at I Care Psych.
- I agree to call 911 or go immediately to an emergency room if the Patient is having an emergency medical event or a situation that could reasonably be expected to develop into an emergency.

BY SIGNING BELOW I CONFIRM I HAVE REVIEWED THE CONTENT OF THIS FORM, HAD AN OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED, AND THAT I AM VOLUNTARILY CONSENTING TO SERVICES TO BE RENDERED TO THE PATIENT BY I CARE PSYCH AND ITS PROVIDERS.

This document is effective until the later of one year from the date of signature below or the conclusion of treatment services.

Patient Name:_____ Date of Birth:_____/_____/_____

Name:_____ Relationship to Patient:_____

Date:_____/_____/_____ Signature: _____

For individuals/representatives acting on behalf of the patient, you must indicate your relationship to the patient above, and attach proof of your authority to act on the patient's behalf if not already provided to us (other than natural parents).