

# Treatment Agreement

As a member of Better Life Partners, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments; to adhere to the payment policy.
2. I agree to conduct myself in a courteous manner to everyone at Better Life Partners.
3. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
4. I agree not to deal, steal, or conduct any illegal or disruptive activities at Better Life Partners.
5. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to Better Life Partners and could result in my treatment being terminated without any recourse for appeal.
6. I agree that my medication/prescription can only be given to me at my regular office visit. A missed visit may result in me not being able to get my medication/prescription until the next visit.
7. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost or stolen medication may not be replaced regardless of the reason it was lost.
8. I agree not to obtain medications from any other doctors, pharmacies, or other sources without telling my treating provider.
9. I agree to comply, in a timely manner, with medical requests made by a provider of which can subsequently affect the care I receive at Better Life Partners.
10. I understand that mixing suboxone, alcohol, and/or other drugs with other medications, especially benzodiazepines (for example Valium, Klonopin, Ativan or Xanax) can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines.
11. I agree to take the medication as my provider has instructed and not to alter the way I take medication without first consulting my provider.
12. I understand that medication alone may not be sufficient treatment for my condition, and I agree to participate in counseling with Better Life Partners weekly. Failure to comply with counseling appointments may result in not receiving my medications until I have seen the counselor.
13. I understand that violations of the contract may be grounds for termination of treatment.



I certify that I am requesting the services of Better Life Partners Inc. for myself, for the purpose of substance use disorder treatment, including screening, assessment, evaluation, diagnosis, and treatment and that I have read and agree to the terms of the above Treatment Agreement.

## Telehealth Consent

As a member of Better Life Partners, I freely and voluntarily agree to accept this telehealth consent as follows:

- I hereby authorize Better Life Partners to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
- I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
- I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
- I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
- I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.



I hereby give Better Life Partners Inc. permission to administer services via telehealth as outlined above.

## Prescription History Consent

As a member of Better Life Partners, I freely and voluntarily agree to accept this prescription history consent as follows:

- I understand that Better Life Partners Inc. will obtain my medication history from my pharmacy, my health plans, other healthcare providers, and/or the prescription drug monitoring program.



I hereby give Better Life Partners Inc. permission to obtain a history of my prescribed drugs as outlined above.

## Authorization to Bill

As a member of Better Life Partners, I freely and voluntarily agree to accept this telehealth consent as follows:

- I request direct payment of authorized insurance (including Medicare, Medicaid, or Medicare Supplemental) benefits or subsidies made, on my behalf, payable to Better Life Partners Inc. for any and all services provided to me. I authorize any holder to release to my insurance company medical information about me needed to determine benefits or benefits payable for related services, regulatory compliance, state audit or quality assurance purposes.
- I understand that Better Life Partners Inc. will submit my insurance claims and that I will be responsible for any deductible, co-payments, co-insurance or member fees at the time services are rendered. I understand that I will receive a monthly statement if my account has a balance due. I understand that Better Life Partners cannot accept responsibility for collection of my insurance claim or for negotiating a settlement of a disputed claim and that I am responsible for payment of my account.
- I understand that my services and/or treatment with Better Life Partners may be terminated in the case of non-compliance. This includes: non-adherence to the Treatment Agreement, instructions regarding prescribed medication, and treatment plans; repeatedly missing appointments; or failure to pay the fees for the services rendered and determined as obligatory by my insurance and the guidelines of this practice.



I hereby give Better Life Partners Inc. permission to bill my insurance as outlined above.

## Messaging Consent

Better Life Partners uses digital messaging formats, like phone, email, and SMS (text) to help coordinate care directly with members (e.g. Appointment reminders, Rescheduling assistance, Prescription related issues). As with other aspects of healthcare, the use of these forms of messaging by healthcare providers/organizations is subject to tight regulation. The Federal Telephone Consumer Protection Act (TCPA), Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) have each established their own criteria around permissible uses of messaging in various healthcare settings. Specifically, under the TCPA, a healthcare provider/organization must obtain prior express consent before calling, faxing or texting an individual, unless one of the healthcare exceptions applies.

As a member of Better Life Partners, I freely and voluntarily agree to accept this messaging consent as follows:

- I hereby provide my express consent for Better Life Partners to coordinate care with me directly using the my preferred communications formats.
- I understand that I can change my preferred communications formats at any time by calling Better Life Partners.



I hereby give Better Life Partners Inc. permission to communicate with me digitally as outlined above.

## Member Bill of Rights

All members of Better Life Partners have the right to:

1. Be cared for with love, belonging, and purpose and without shame, stigma, or judgment regarding the symptoms and chronic disease of addiction;
2. Be fully informed about the program, what to expect from treatment, and possible outcomes;
3. Receive confidential, evidence-based treatment from professionals who are knowledgeable, trained, and licensed or certified, as appropriate;
4. Be treated, or referred for contemporaneous treatment, for any co-occurring mental or physical health disorders;
5. A personalized treatment plan with frequent assessment, shared decision making, and the right to remain in treatment as long as is necessary and effective;
6. Education and support for families, friends, and loved ones;
7. Clean, safe, community-based treatment environments that provide partnering services that support recovery success.

### Process for Filing a Complaint or Grievance:

Any member of Better Life Partners (BLP) can file a complaint about a staff member, provider, counselor, or about our treatment services or sites, by contacting our Compliance Department, at [compliance@betterlifepartners.com](mailto:compliance@betterlifepartners.com), or calling 866-679-0831.

When a complaint is received, BLP will confirm receipt of the complaint, investigate, and respond with an initial reply within 48 hours.

# New Member Orientation

I will attend an Orientation session where I will be assigned to my primary meeting and review the following:

- BLP's Program Rules and Member information
- Member's Rights
- Explanation of the complaint and grievance process
- Description of different ways I can provide input into my services and provide feedback.
- BLP's confidentiality policies, which include reference to 42 C.F.R, part B, para 2.22 and HIPAA
- Information about behavioral expectations & consequences of members
- Criteria for being admitted to services, being transitioned to a different service, and being discharged.
- BLP's staff response if they identify potential risk to my wellbeing.
- BLP's hours of operation and how to access after-hour-services.
- Information about BLP's standard of professional conduct.
- Possible mandated reporting and follow-up requirements for clients who are mandated (court-ordered) to services, regardless of discharge status.
- Description and explanation of financial obligations, fees, and any financial arrangements for services performed by BLP.
- BLP's health and safety policies regarding prohibition of restraint/seclusion, use of tobacco products, legal and illegal drugs, prescription medications, and weapons brought into any BLP facility, program, or activity.
- A tour of the facility if relevant including: emergency exits, fire suppression equipment, first aid kits, emergency shelters, bathrooms, and group therapy room.
- How the Treatment Plan will be developed with member participation
- The expected course of treatment; how motivational incentives may be used; expectations for family involvement; and expectations for legally required appointments, sanctions, or court notifications.
- Coordination of services



I certify that I will attend an Orientation session where I will be assigned to my primary meeting and review the information outlined above.

## Confidentiality and Privacy Practices Statement

### Notice of Better Life Partners Confidentiality and Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to ask each of our patients to acknowledge receipt of our Notice of Privacy Practices. The Notice is published on this page. You acknowledge receipt of this notice by accepting terms and conditions for joining Better Life Partners.

Better Life Partners, Inc and Better Life Partners LLC, Better Life Partners Provider Group and Better Life Partners Counselor Group designate themselves as a single Affiliated Covered Entity ("ACE") for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and 42 CFR Part 2. Each of the entities, sites, locations and care providers will follow the terms of this joint notice. In addition, the entities, sites, locations and care providers may share medical information with each other for treatment, payment, or health care operations related to the ACE. This designation may be amended from time-to-time to add new covered entities that are under common control with Better Life Partners.

### Better Life Partners Responsibilities

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part 2, Better Life Partners must take steps to protect the privacy of your "Protected Health Information" (PHI). PHI includes information that we have created or received regarding your health or payment for your health. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

Under federal law, we are required to:

- Protect the privacy of your PHI. All of our employees and physicians are required to maintain the confidentiality of PHI and receive appropriate privacy training
- Provide you with this Notice of Privacy Practices explaining our duties and practices regarding your PHI
- Follow the practices and procedures set forth in the Notice

### Uses and Disclosures of Your Protected Health Information That Do Not Require Your Authorization

Better Life Partners uses and discloses PHI in a number of ways connected to your treatment, payment for your care, and our health care operations. Some examples of how we may use or disclose your PHI without your authorization are listed below.

## Treatment

- To our providers, counselors and care coordinators involved in your health care or treatment.
- To our different departments to coordinate such activities as prescriptions and lab work.
- To other health care providers treating you who are not on our staff such as dentists, emergency room staff, and specialists. For example, if you are being treated for an injured knee we may share your PHI among your primary physician, the knee specialist, and your physical therapist so they can provide proper care.

## Payment

- To administer your health benefits policy or contract.
- To bill you for health care we provide.
- To pay others who provided care to you.
- To other organizations and providers for payment activities unless disclosure is prohibited by law.

## Healthcare Operations

- To administer and support our business activities or those of other health care organizations (as allowed by law) including providers and plans. For example, we may use your PHI to review and improve the care you receive and to provide training.
- To other individuals (such as consultants, researchers, and attorneys) and organizations that help us with our business activities. (Note: If we share your PHI with other organizations for this purpose, they must agree to protect your privacy.)

## Other

We may use or disclose your Protected Health Information without your authorization for legal and/or governmental purposes in the following circumstances:

- Required by law - When we are required to do so by state and federal law, including workers' compensation laws.
- Public health and safety - To an authorized public health authority or individual to: Protect public health and safety.
- Prevent or control disease, injury, or disability.
- Report vital statistics such as births or deaths.
- Investigate or track problems with prescription drugs and medical devices. (Food and Drug Administration.)
- Abuse or neglect - To government entities authorized to receive reports regarding abuse, neglect, or domestic violence (per State law - mandated reporting)
- Credible threats of violence against another individual (per Tarasoff Ruling)
- Oversight agencies - To health oversight agencies for certain activities such as audits, examinations, investigations, inspections, and licenses.
- Legal proceedings - In the course of any legal proceeding in response to an order of a court or administrative agency and, in certain cases, in response to a subpoena, discovery request, or other lawful process.
- Law enforcement - To law enforcement officials in limited circumstances for law enforcement purposes. For example disclosures may be made to identify or locate a suspect, witness, or missing person; to report a crime; or to provide information concerning victims of crimes.
- Military activity and national security - To the military and to authorized federal officials for national security and intelligence purposes or in connection with providing protective services to the President of the United States.

We may also use or disclose your Protected Health Information without your authorization in the following miscellaneous circumstances:

- Family and friends—To a member of your family, a relative, a close friend—or any other person you identify who is directly involved in your health care—when you are either not present or unable to make a health care decision for yourself and we determine that disclosure is in your best interest. For example, we may disclose PHI to a friend who brings you into an emergency room.
- All of this information except religious affiliation will be disclosed to people who ask for you by name. Members of the clergy will be told your religious affiliation if they ask. This is to help your family, friends, and clergy visit you in the facility and generally know how you are doing.
- Treatment alternatives and plan description—To communicate with you about treatment services, options, or alternatives, as well as health-related benefits or services that may be of interest to you, or to describe our health plan and providers to you.
- De-identify information—If information is removed from your PHI so that you can't be identified, as authorized by law.
- Coroners, funeral directors, and organ donation—To coroners, funeral directors, and organ donation organizations as authorized by law.
- Disaster relief—To an authorized public or private entity for disaster relief purposes. For example, we might disclose your PHI to help notify family members of your location or general condition.
- Threat to health or safety—To avoid a serious threat to the health or safety of yourself and others.
- Correctional facilities—If you are an inmate in a correctional facility we may disclose your PHI to the correctional facility for certain purposes, such as providing health care to you or protecting your health and safety or that of others.

## Uses and Disclosures of Your Protected Health Information That Require Us to Obtain Your Authorization

Except in the situations listed in the sections above, we will use and disclose your PHI only with your written authorization. This means we will not use your Protected Health Information in the following cases, unless you give us written permission:



#### Marketing Purposes

- Sale of your information
- Most sharing of psychotherapy notes

In some situations, federal and state laws provide special protections for specific kinds of PHI and require authorization from you before we can disclose that specially protected PHI. In these situations, we will contact you for the necessary authorization. In some situations, you may revoke your authorization; instructions regarding how to do so are contained in the form authorization you obtain from us. If you have questions about these laws, please contact the Privacy Officer at 866-679-0831.

#### Your Rights Regarding Your Protected Health Information

You have the right to:

- Request restrictions by asking that we limit the way we use or disclose your PHI for treatment, payment, or health care operations. You may also ask that we limit the information we give to someone who is involved in your care, such as a family or friend. Please note that we are not required to agree to your request except when a restriction has been requested regarding a disclosure to a health plan in situations where the patient has paid for services in full and where the purpose of the disclosure is for payment or healthcare operations. If we do agree, we will honor your limits unless it is an emergency situation.
- Ask that we communicate with you by another means. For example, if you want us to communicate with you at a different address we can usually accommodate that request. We may ask that you make your request to us in writing. We will agree to reasonable requests.
- Request an electronic or paper copy of your PHI. We may ask you to make this request in writing and we may charge a reasonable fee for the cost of producing and mailing the copies, which you will receive usually within 30 days. In certain situations we may deny your request and will tell you why we are denying it. In some cases you may have the right to ask for a review of our denial.
- Ask usually to amend PHI about you that we use to make decisions about you. Your request for an amendment must be in writing and provide the reason for your request. In certain cases we may deny your request, in writing. You may respond by filing a written statement of disagreement with us and ask that the statement be included with your PHI.
- Seek an accounting of certain disclosures by asking us for a list of the times we have disclosed your PHI. Your request must be in writing and give us the specific information we need in order to respond to your request. You may request disclosures made up to six years before your request. You may receive one list per year at no charge. If you request another list during the same year, we may charge you a reasonable fee. These lists will not include disclosures to other organizations that might pay for your care provided by Better Life Partners.
- Request a paper copy of this Notice.
- Receive written notification of any breach of your unsecured PHI.
- File a complaint if you believe your privacy rights have been violated. You can file a written complaint with us at the address below, or with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints).

#### Email

By utilizing our services or replying to our emails, you acknowledge that you are aware that email is not a secure method of communication, and that you agree to the risks. If you would prefer not to exchange personal health information via email, please notify us at [compliance@betterlifepartners.com](mailto:compliance@betterlifepartners.com).

#### Changes to Privacy Practices

Better Life Partners may change the terms of this Notice at any time. The revised Notice would apply to all PHI that we maintain. We will make any such changes to our website.

#### Questions and Complaints

If you have any questions about this Notice or would like an additional copy, please contact the Privacy Officer at 1-866-679-0831 or [compliance@betterlifepartners.com](mailto:compliance@betterlifepartners.com).

If you think that we may have violated your privacy rights or you disagree with a decision we made about access to your PHI, you may send a written complaint to the Compliance Officer at PO Box 5518, Hanover, NH 03755.

I certify that I am requesting the services of Better Life Partners Inc. for myself, for the purpose of substance use disorder treatment, including screening, assessment, evaluation, diagnosis, and treatment and that I have read and agree to the terms of the above Treatment Agreement.