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Throughout this document, Better Life Partners Inc. and Belonging Medical Group PLLC are referred to as "Better Life Partners".

I. Treatment Agreement

As a member of Better Life Partners, I agree to accept this treatment agreement.

A. Member Bill of Rights

As a member of Better Life Partners, I have the right to:

- Be cared for with belonging, love, and purpose;
- Be treated with respect and without shame, stigma, or judgment regarding the symptoms and chronic disease of addiction;
- Be fully informed about the program, what to expect from treatment, and possible outcomes;
- Receive confidential, evidence-based treatment from professionals who are knowledgeable, trained, and licensed or certified, as appropriate;
- Be treated, or referred for contemporaneous treatment, for any co-occurring mental or physical health disorders;
- Receive a personalized treatment plan with frequent assessment, shared decision making, and the right to remain in treatment as long as is necessary and effective;
- Be provided education and support for families, friends, and loved ones;
- Receive care in clean, safe, community-based treatment environments that provide partnering services that support recovery success, if I access care at an in-person Better Life Partners location.

I understand my rights as a Member of Better Life Partners.

B. Prescription Policies & Consent

As a member of Better Life Partners, I freely and voluntarily agree to adhere with the 1

prescription and medication policies as follows:

- 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 is against the law. Such mishandling would result in my treatment being terminated.

- 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.
- I understand that I must attend my scheduled appointments with counselors and/or providers at Better Life Partners to obtain some of my prescriptions from Better Life Partners.
- 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.
- I agree to make every effort to tell my Better Life Partners provider about other medications I receive from any other doctors, pharmacies, or other sources.
- 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.
- 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.
- I understand that medication alone may not be sufficient treatment for my condition, and I agree to participate in care with Better Life Partners based on the expectations of my program.
- 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 agree to adhere to Better Life Partner's prescription policies, and hereby give Better Life Partners Inc. permission to obtain a history of my prescribed drugs, as outlined above.

C. Medical Treatment Consent

As a member of Better Life Partners, I agree to accept this Medical Treatment consent as follows:

- I voluntarily authorize medical treatment as deemed necessary and appropriate by the clinical and care team of Better Life Partners.
- I will provide all necessary information related to my healthcare needs that may affect the treatment I may receive, including but not limited to past medical history, past and current medications, and current medical issues.
- With my consent, Better Life Partners may use and disclose Protected Health Information (PHI), about me to carry out treatment, payment, and healthcare operations. Please refer to the Better Life Partners Confidentiality and Privacy Practices for a more complete description of such uses and disclosures.
- I understand that if I do not provide all pertinent information pertaining to my current health, that I will not hold the clinical and care team nor Better Life Partners liable for any adverse reactions.

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- [Maine members only]: If I am receiving care from a provider who is an Opioid Health Home, I agree to end care with this provider and have Better Life Partners be the sole Opioid Health Home provider.

I give Better Life Partners Inc. permission to administer medical treatment as outlined above.

II. Telehealth Consent

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

- I 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 may not 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 give Better Life Partners Inc. permission to administer services via telehealth as outlined above.

III. 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 agree to accept this messaging consent as follows:

- I provide my express consent for Better Life Partners to coordinate care with me directly using my preferred communication formats.
- I agree to allow Better Life Partners to send text messages to remind me about appointments, and I will inform Better Life Partners if I no longer wish to

receive messages.

- I understand that I can change my preferred communication formats at any time by calling Better Life Partners.
- I understand that I am required to identify at least one primary communication method at all times for contact.

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

IV. Authorization to Bill

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

- I agree to adhere to the payment policy.
- 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. or Belonging Medical Group PLLC 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 Partner 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 give Better Life Partners Inc. permission to bill my insurance as outlined above.

New Member Orientation

I will attend an Orientation session where I will learn about program expectations, and review the following:

- Better Life Partners' 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. Better Life Partners' 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.
- Better Life Partners' Staff response if they identify potential risk to my wellbeing. 4
- Better Life Partners' hours of operation and how to access after-hour-services.
 - Information about Better Life Partners' 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 Better Life Partners.
- Better Life Partners' health and safety policies regarding prohibition of restraint/seclusion, use of tobacco products, legal and illegal drugs, prescription medications, and weapons brought into any Better Life Partners 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.

V. Process for Filing a Complaint

Any member of Better Life Partners can file a complaint about a staff member, provider, counselor, or about our treatment services or sites, by completing the Member Complaint Form available in the subtext of our website, located at www.betterlifepartners.com or contacting our Compliance Department, at compliance@betterlifepartners.com.

I understand that when a complaint is received, Better Life Partners will confirm receipt of the complaint, investigate, and respond with an initial reply within 48 hours.

VI. 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

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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

Disclosure With Written Consent

As outlined in Federal Confidentiality Law 42 CFR Part 2, disclosure of your records can only be made if you have signed a consent form allowing for this disclosure. Typically, these disclosures are made to others who are involved in your treatment such as primary care physicians, case managers, mental health providers, etc. You will also be asked to sign a release of information to your emergency contact.

Although a Release of Information is not required, please note we will be unable to discuss your relationship with Better Life Partners, disclose any requested information, including but not limited to meeting dates, times, or access codes for scheduled meetings, with anyone who calls on your behalf unless there is a Release of Information on file for that person or organization. Releases of Information and Emergency Contacts can be added or removed at any time upon request.

Disclosure Without Consent

Under certain situations, your PHI can be disclosed without your consent:

- Medical Emergencies: If an emergency occurs and your consent cannot be obtained, we may disclose PHI to medical personnel. The PHI disclosed can only be that which is pertinent to the medical emergency
- Research: An individual or entity conducting scientific research. The researchers are bound by the same confidentiality requirements
- Audit and Evaluation: Any federal, state, or local governmental agency that provides financial assistance are authorized by law to audit and evaluate Better Life Partners practices to ensure we are providing quality services. These agencies are bound by the same confidentiality requirements
- To report a crime on program premises or against Better Life Partners personnel
- To prevent multiple enrollments through Prescription Drug Monitoring Programs
- To report suspected child abuse and/or neglect
- Internal Communication
- To Agencies with whom Better Life Partners has a Qualified Service Organization Agreement (QSOA)

Web Information Technology System (WITS) Information Use Acknowledgement

For any clients who are receiving treatment services that are funded in any part by the Department of Health and Human Services (DHHS), Bureau of Drug and Alcohol Services (BDAS), providers are required to enter a certain minimum set of information into the WITS system in order to meet billing and reporting requirements. In some cases, providers utilize WITS as their client record keeping system and may enter more than the minimum required data set. Regardless of how much information is entered into the WITS system, Federal law (42 CFR, Part 2), prohibits disclosure of the information without client consent except in very limited circumstances.

Because the WITS system is maintained by BDAS, certain DHHS employees are authorized to access the information that is entered in the WITS system. These DHHS employees are bound by State and Federal law (42 CFR, Part 2) and DHHS policy to keep the information in WITS confidential and to only access it for legitimate business purposes. In general, once information is entered into WITS, it cannot be removed. As stated above, the sharing of client identifiable information outside of the DHHS without written consent from the client is prohibited by State and Federal law and DHHS policy.

Some examples of when client information is accessed and how it is used are:

- Technical assistance with utilizing the WITS system;
- Technical assistance with clinical decision making upon provider request;
- Billing and payment;
- Reporting of de-identified client data to meet funding requirements, legislative requests, and other informational needs; and
- Quality monitoring, audit and improvement.

I indicate that I understand that having my personal information entered into the WITS system will result in DHHS employees having access to that information for legitimate business purposes.

↑-----**NH Members Only**-----↑

↓-----**Maine Members Only**-----↓ 7

Health Info Net Educational Information

Better Life Partners participates in the state-wide health information exchange called HealthInfoNet. This means your health information, maintained electronically, may be accessed by Better Life Partners to provide care. Specially protected information including substance abuse records, mental health records, HIV/AIDS information and genetic test results are not automatically included in HealthInfoNet.

To “**opt-in**” sharing of mental health records access, complete this form online at <https://map.hinfonyet.org:8443/patientoptions/mhhivin> or by calling 866-592-4352. If you do not wish to be included in HealthInfoNet, you may “**opt-out**” by filling out a form found online at <http://www.hinfonyet.org/patients/your-choices>, or calling 866-592-4352. If you change your mind, you may choose to join again later, but your previous health information will not be included.

Additional information can be found here:

The law allows us to use or disclose your protected health information in certain situations, including:

- When required by state or federal law
- To report abuse or neglect
- To persons authorized by law to act on your behalf
- For Public Health
- Department of Health and Human Services to determine our compliance
- Imminent threat to yourself or others

I certify I reviewed the information above and am now participating in Health Info Net, and understand I can opt out of sharing my health information by using the Opt Out link above.

↑-----**Maine Members Only**-----↑

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.

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.

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 Quality and Compliance Lead at Compliance@betterlifepartners.com

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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 Lead at PO Box 5518, Hanover, NH 03755.

VII. Final Consent and Agreement

I certify that I am requesting the services of Better Life Partners Inc. and its clinical associates for myself, including screening, assessment, evaluation, diagnosis, and treatment.

I certify that I have read and agree to the terms of the Treatment Agreement, Telehealth Consent, Messaging Consent, Authorization to Bill, Process for Filing a Complaint, and Confidentiality and Privacy Practices Statement, as written above.

DISCLAIMER: By printing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Member Name: _____ Date: _____

VIII. Consent to Exchange Information for Treatment, Payment, and Healthcare Operations Purposes

Member Name: _____ DOB: _____

By signing this Consent, I authorize Better Life Partners to exchange my information with my treating providers, other people assisting in my treatment or coordination of care, health plans, third-party payers, and people helping to operate Better Life Partners' programs (collectively, "Recipients") for purposes of treatment, payment, and health care operations.

The information exchanged may include my presence in substance use disorder treatment, treatment plans, progress notes, physician orders, history and physical, psychiatrist assessments, biopsychosocial assessments, discharge planning and summary, laboratory test results, medications, and other information related to my care and treatment at Better Life Partners.

Complete the following: I agree my HIV/AIDS information may be disclosed.

Yes No If yes, please sign here: _____

Statement of Consent

I understand that:

- Information exchanged pursuant to this Consent may be subject to redisclosure by the Recipient of such information and may no longer be protected by 42 C.F.R. Part 2, the federal law protecting the confidentiality of substance use disorder records at Better Life Partners. If the Recipient of my information is a covered entity or business associate that receives it for purposes of treatment, payment, or health care operations, my information may be redisclosed in accordance with the Health Insurance Portability and Accountability Act and its implementing regulations (HIPAA), except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me.
- I may revoke this Consent in writing at any time by mailing Better Life Partners, Attn: Medical Records Department, PO Box 1110, Watertown, MA 02471, by

telephone at (866) 679-0831, or by email at records@betterlifepartners.com, except to the extent that action has already been taken in reliance on it.

- If I refuse to sign this Consent, Better Life Partners may determine it cannot provide me with ongoing treatment.
- **This Consent does not expire and remains in effect until I revoke it.**

Member Signature: _____ **Date:** _____

If signed by the member's personal representative:

Print Name: _____

Relationship to Member: _____