PATIENT SERVICES AGREEMENT

Patient Name: _____
Patient DOB: _____

A. INFORMED CONSENT TO TREATMENT

1. Outpatient Therapy. I give LIfestance[1] and the professional staff with or employed by LifeStance permission to perform all necessary care to treat me through outpatient therapy including counseling, psychotherapy, psychological assessment and/or psychiatric care. I understand that outpatient therapy has both benefits and risks. Risks may include the experiencing of uncomfortable or distressing feelings such as anger, frustration, anxiety, sadness, fear, guilt or helplessness because coming to therapy often requires discussion of unpleasant traumatic aspects of life. However, therapy also has many benefits if I am willing to put forth the effort required, maintain an open and motivated approach to sessions, and am willing to engage in conversation with my providers if I believe an aspect of services need to change. These benefits include, but are not limited to, increased insight and understanding of current challenges, increase in positive experiences and relationships, increased ability to cope and manage negative emotions and situations, and problem acceptance and resolution. Still, there are no guarantees about what will happen and additional referrals to better address the presenting challenges may be warranted. We will consider that you are no longer a patient at LifeStance if you have 1) not been seen by a clinician in the service line in 90 days, 2) no future appointment scheduled, and 3) no communication to us regarding a desire to continue services.

2. Minor Patients. If the patient is a minor unable to consent to treatment independently, I, as the parent or legal guardian, understand that outpatient therapy may include the experiencing of uncomfortable or distressing feelings for my child/adolescent but also for me as the parent/guardian, and potential increase in behavioral issues as difficult issues are processed and strategies to modify the behaviors are implemented. I understand there is a risk of disagreement between parents or parents and the therapist regarding treatment. LifeStance will work to resolve these differences in the interest of my child/adolescent's therapeutic progress. However, parents/guardians ultimately decide whether services will continue. Additional details regarding the child/adolescent are set forth in the Minor Patient Addendum, which must be completed prior to the first service appointment. A minor able to consent to treatment independently will be deemed to have done so unless a Minor Patient Addendum has been completed by the adolescent's parent or guardian. You agree to provide LifeStance Health with a copy of all legal documents, including Custodial Agreements and Parenting Agreements that specify or authorize individuals responsible for Medical Decision-Making (including Medication Management). These documents should be made available at the first appointment or immediately thereafter. If 60 days elapse following a request for these records without a response. LifeStance Health reserves the right to discontinue treatment.

3. Couples Therapy. You understand by consenting to this process contingent upon state regulations it is possible that the partner of the covered beneficiary may have a right to access treatment records without beneficiary consent.

4. COVID-19 and In-Person Services. I understand that by coming to the office, I am assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if I travel by public transportation, cab, or ridesharing service. LifeStance has taken steps to reduce the risk of spreading the virus within the office, and LifeStance has posted our efforts on our website and in the office.

5. Telehealth Services. I understand that LifeStance providers may provide me with services via telehealth modalities, and I authorize my LifeStance providers to do so at times in lieu of interacting with me in-person during a traditional practitioner-patient office visit, when such is permitted by state and federal law. I also understand that telehealth is the delivery of healthcare services using technology when the healthcare provider and the patient are not in the same physical location. I understand that there are risks and benefits associated with telehealth services and that there are circumstances and conditions specific to telehealth services, as follows:

i. *Potential Benefits of Telehealth Services*. My provider may choose to deliver services via telehealth because there are potential benefits associated with telehealth services as follows:

a. A patient is able to remain at a remote site while the healthcare provider receives information and provides healthcare advice at a different site.

b. The telehealth encounter may result in more efficient, timely and cost-effective healthcare evaluation and management.

c. The telehealth encounter may allow the provider or patient to obtain the expertise of a distance specialist that would otherwise not be available if a traditional in-person interaction is required.

ii. *Potential Risks of Telehealth Services*. As with any healthcare procedure or service, there are potential risks associated with the use of telehealth services, which include, but may not be limited to, the following:

a. Telehealth-based services and care may not be as complete as face-to-face services for certain patient needs and circumstances.

b. There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties and that I may not hold LifeStance or my healthcare provider liable for technology failures.

c. My healthcare provider or I may unilaterally choose to discontinue the telehealth encounter if it is determined the technology is not appropriate under the circumstances.

d. I have the right to withhold or withdraw my consent to the use of telehealth and/or telehealth services in the course of my care at any time, without affecting my right to be referred for future care or treatment from a qualified provider who provides in-person care.

e. A variety of alternative methods of health care may be available to me from other healthcare providers, such as an in-person encounter in lieu of a telehealth encounter, and that I may choose one or more of those options at any time from a provider who may, or may not, be affiliated with LifeStance.

f. Telehealth may involve electronic communication of my personal healthcare information to other healthcare practitioners who may be located in other areas, including out-of-state or internationally, when appropriate for providing me with care that I request.

g. All existing confidentiality protections apply to telehealth encounters, and I have the right to access all healthcare information related to telehealth encounters and to receive copies of such information at cost upon request.

h. There will be no further dissemination of any of my protected health information to other entities without my further written consent, or as otherwise permitted by law.

i. People other than my healthcare provider may be present in order to facilitate the telehealth consultation, and I will be informed of their presence.

j. I have the right to any healthcare records created as a result of a telehealth encounter and all records will be maintained in a manner that is in compliance with state and federal patient privacy laws.

k. My telehealth encounters will not be recorded without my express written consent.

l. When using technology to facilitate healthcare delivery, there may be cultural or language differences that may affect the delivery of services and there may be time zone differences between me and my healthcare provider(s).

m. There is the possibility of the denial of insurance benefits for telehealth encounters.

n. I will be provided with information regarding my healthcare provider(s)' training credentials, license number, physical location and contact information.

o. I will be provided with LifeStance's social media policy, encrypting policy, policies on the collecting, documentation, tracking, and storage of my personal information.

p. It is my duty to inform my healthcare provider of electronic or in-person interactions regarding my care that I may have with other healthcare providers.

q. I may expect the anticipated benefits from the use of telehealth services in my care, but no results can be guaranteed or assured.

r. I will have the opportunity to ask my healthcare provider any questions I may have regarding this consent before proceeding with a telehealth encounter.

6. Medication Data. I understand that information regarding medications currently in use can assist providers in tailoring therapy to be more effective and also to assist in avoiding side effects or adverse reactions due to conflicting prescriptions. As an exercise of my individual right of access, I authorize my provider to access and import into LifeStance's electronic patient record, all available information regarding drugs dispensed to me at any time in the past (collectively, "Dispensed Drug History"), regardless of source or circumstance. I understand that LifeStance will incorporate my Dispensed Drug History into its legal patient record and will only use or disclose my Dispensed Drug History as described in its Notice of Privacy Practices or as permitted or required by applicable law.

7. State Addendum. I acknowledge that I have accessed and reviewed the state-specific addendum applicable to LifeStance Behavioral Health Entity providing my care.

8. Text/Email Communication. LifeStance understands that we live our lives in email and text and that these might be the most convenient ways for us to communicate with you about our services, your health and your appointments. LifeStance also understands that the information you share with us is sensitive and we take the privacy and security of your personal health information very seriously. We want to strike the right balance for you. We will send you emails and texts regarding our services, your appointments, and products we may offer unless you tell us not to do so. Please note that sending this information over unencrypted email creates the potential for unauthorized parties to intercept your information. Similarly, if someone else has access to your email account, they may see this information. These kinds of unauthorized access can allow someone to know you are receiving behavioral health care and, in extreme cases, with other information that may be available about you from other sources, leading to medical identity theft. If you are not comfortable accepting these risks, please check the box below and sign this form. Please note we require 72 business hours' notice to respond to medication refill requests. Please note we make every reasonable attempt to respond to patient portal messages within 72 business hours.

☐ I do not want to receive communications from LifeStance via text and email.

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____

B. FEES, THIRD-PARTY PAYORS AND SELF-PAY TIERS

I agree to pay LifeStance for all charges incurred for services LifeStance renders to me, and I assign to LifeStance any monies due and owing under my health insurance plan or other third-party payor, including government payors, worker's compensation payors, personal injury case defendants and medical benefits accident insurance payors ("Med Pay"). I understand and agree that:

1. Primary Payment Responsibility. All LifeStance invoices for services and costs are due upon receipt, and all copay, coinsurance, and deductible amounts are due at the time service is delivered. LifeStance accepts credit and debit card (collectively "credit card") payments. I understand that LifeStance uses a third-party service that facilitates in-person and online payment transactions and that LifeStance will not directly keep my credit card information on file. I grant LifeStance the right to automatically charge my credit card on file in each of the circumstances specifically identified in this agreement through the third-party service that LifeStance uses to facilitate credit card transactions.

2. Missed Appointments. A minimum of two business days' notice is required for cancelled and missed appointments. If this notice is not received or if the patient fails to show for the appointment within the first 15 minutes of the scheduled appointment, I agree to be personally responsible for payment for the full amount for the time reserved for the appointment. I grant LifeStance the right to charge my credit card on file for the full reserved appointment time. I understand that health insurance does not pay for missed appointments. If unforeseen situations arise, such as illness, bereavement, and accidents, etc., I will provide documentation that will support my missed visit to avoid being invoiced for the full amount.

3. Third-Party Payors, Generally. I am responsible for all monies due and owing for services rendered by LifeStance in the event that any third-party payor does not pay for these services. It is ultimately my responsibility to ensure that any third-party payor covers, and makes timely payment for, LifeStance's services. In the event that any monies received for LifeStance from a third-party payor which the payor later recoups from LifeStance any time after their receipt, I will be responsible for those monies then due and owing. I grant LifeStance the right to charge my credit card on file for all requested services or tests: (i) at the time of service delivery; (ii) upon notice from a third-party payor that any full or partial charges are not covered by the third-party payor and/or (iii) if any previously paid amounts are recouped by the third-party payor.

4. Self-Pay Only with Health Insurance Coverage. If I have health insurance coverage that may cover some or all of the services provided by LifeStance, but I choose to self-pay and not use insurance to cover any LifeStance services, I understand that I will be full responsible for payment of all services at the time of service delivery. I grant LifeStance the right to charge my credit card on file for all requested services or tests. By choosing this self-pay only option, I agree to not submit claims for LifeStance services to my health plan for reimbursement, and that any payments I make to LifeStance will not be credited toward satisfying any deductible or cost-sharing obligations I may have under my health insurance plan.

5. Self-Pay Combined with In-Network Health Insurance Coverage. I understand that if my LifeStance provider is an in-network provider for my health insurance plan, LifeStance may not bill me directly for any services that are otherwise covered under my health insurance plan. I

certify that I have verified that any self-pay services I request of my LifeStance provider are not covered services under my health plan. For any services or tests that are not covered by my health insurance plan, I grant LifeStance the right to charge my credit card on file for all requested services or tests at the time of service delivery or upon insurance denial of coverage. For cost sharing, the right to charge my credit card on file for all requested services or tests at the time of service delivery or upon notice from the health insurance company that any LifeStance charges are the patient's responsibility.

6. Self-Pay and Government Payors. I understand that most LifeStance providers are participating providers for government-sponsored health plans and that LifeStance may not bill me directly for any services that are otherwise covered for me by government payors. I certify that I have verified that any self-pay services I request of my LifeStance provider are to covered services under any government-sponsored health plans under which I am a covered participant. I grant LifeStance the right to charge my credit card on file for all requested services or tests at the time of service delivery or upon notice from the government payor that any LifeStance charges are the patient's responsibility that are not covered services.

7. Self-Pay and No Health Insurance. If I do not have health insurance or qualify for government payor benefits for LifeStance services, I understand that I will be fully responsible for payment of all services at the time of service delivery, and I grant LifeStance the right to charge my credit card on file for all requested services or tests.

8. Off-Label Treatments and Tests, Generally. Many clinically appropriate medications, assessments or treatments are not currently FDA-approved or are considered experimental by third-party payors and may not be reimbursable from third-party sources. I grant LifeStance the right to charge my credit card on file for all requested off-label treatment or tests not covered by third-party payors at the time of service delivery or upon notice of denial of payment by a third-party payor.

9. Full Coverage for Testing and Assessments. Coverage and cost for psychological and psychiatric assessments and tests vary across different third-party payors, and I am responsible for costs associated with the costs for the tests regardless of whether the costs are reimbursable by third-party payors on my behalf. This is because not all psychological testing services are guaranteed to be covered by third-party payors. At times, third-party payors do not fully reimburse psychological testing services, regardless of whether your clinician is an in-network or out-of-network provider. There are a variety of situations when this occurs; for example, when: (a) the third-party payor does not consider psychological testing "medically necessary" for "experimental" or "investigational" diagnoses; or (b) when the third-party payor reimburses for fewer hours than billed by LifeStance based on what the LifeStance provider has determined to be clinically appropriate or necessary to administer the tests, scoring the tests, preparing the test report, and discussion of the results with the patient and/or attorneys. I understand that I will be fully responsible for payment of all services upon service delivery or upon notice of denial of payment by a third-party payor. I grant LifeStance the right to charge my credit card on file for all requested services or tests not covered by third-party payors at the time of service delivery or upon notice of denial of payment by a third-party payor.

10. Collections. In the event my account is turned over to an attorney or agency for collection, I agree to pay all costs of collection including, but not limited to, court costs and collection fees.

If my account is not paid when due, a service fee and/or interest will accrue as permitted by law.

11. Other Insurance or Litigation Payor Sources. With respect to any administrative cases or personal injury cases, I am responsible for fees incurred when due regardless of the outcome of pending litigation. The fees incurred will be in accordance with LifeStance's standard fees for court testimony, depositions, and other litigation support as itemized in LifeStance's then-current chargemaster. I grant LifeStance the right to charge my credit card on file for all requested services, fees or tests at the time of service delivery. If there are any remaining balance(s) due at the time of case settlement, I authorize and will require my attorney to pay my outstanding accounts with LifeStance in first priority for payment from the settlement proceeds. LifeStance does not accept contingency fee arrangements.

12. Med Pay Coverage. In the vent that I have Med Pay coverage, I permit LifeStance to classify and treat the Med Pay payor as the primary insurer over any other third-party payors. I irrevocably agree to a waiver permitting payment of Med Pay funds directly to LifeStance first in priority over me personally and any other potential claimant to the funds.

13. Forensic and Medical-Legal Requests. If applicable, forensic and medical-legal requests, conferences and telephone calls involve additional time and record-keeping for LifeStance, and I am responsible for all direct costs and expenses associated with LifeStance, and its attorneys and agents, in responding to discovery requests (including depositions and subpoena duces tecum time and labor costs) and with conferences including, but not limited to, court appearances, preparation of reports, photocopying, faxes, long-distance telephone calls, out of office travel, overnight delivery and courier services. I grant LifeStance the right to charge my credit card o file for all such requested forensic and medical-legal services and documentation time.

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____

[1] "LifeStance" includes LifeStance Health, LLC, and the Behavioral Healthcare Entities that LifeStance Health, LLC, manages. The Behavioral Healthcare Entities that LifeStance Health, LLC, manages are provided at the following URL: https://lifestance.com/, as updated from time to time.

MINOR CHILD ADDENDUM

Form must be completed for all persons seeking treatment age 18 or younger

I, _____, state and attest that I may legally consent to medical, mental health and/or substance abuse treatment for the above-listed minor child under the following authority:

☐ Self (able to consent at 14 years old)
☐ Biological or Adoptive Parent
☐ Department of Human Services (DHS)
☐ Guardian/Legal Custodian/Other

Divorce Proceedings or Other Legal Proceedings
Have there been any legal proceedings or actions that have affected the decision-making authority regarding the minor child, including but not limited to: divorce proceeding, legal separation proceeding, paternity proceeding, termination or limitation of parental rights, proceedings regarding participation in therapy, or an assignment of legal custody/guardianship?

☐ Yes ☐ No

Documentation
Do legal documents exist that in any way address or affect the legal authority to make medical decisions for the minor client or that in any way address participation in therapy, contact between a minor child and a parent, or provision for payment of medical or therapy bills? Such documents may include court orders, separation agreements, etc.

☐ Yes ☐ No

The person signing this statement should attach documents verifying their legal authority to make medical decisions for the minor child, unless the person signing is the child or if the person signing is the biological or adoptive parent of the child and there have been no legal proceedings or actions that have affected their decision-making authority regarding the minor child.

Names of all other persons with medical decision-making authority: _____

I attest that the information communicated in this form is complete and accurate to the best of my understanding.

Date: _____

Parent/Guardian/Client Signature: _____

Relationship to the Child: _____

(A signature is required for the information on this form to be considered valid.)