stepworks

Letter for Guardians

Stepworks' mission is to help people hurt by addiction reclaim their dignity and build a better life. To achieve that goal, our team members live by this motto: "We'll walk with you." As your loved one takes their first steps toward a better future, thank you for trusting us to walk with them and play a vital role in their recovery.

This packet contains the following documents:

- guardian and emergency contact information
- consent to treat
- HIPAA privacy practices
- fee agreement
- treating provider release
- COVID-19 Patient Disclaimer
- special event authorization for release of information (optional)
- media release (optional)
- general release

What to know about the general release

- We can only release information to people for which we have a general release.
- We cannot even acknowledge that a patient is at our facility without it.
- Please make as many copies as needed and complete a release for each person.

Depending on the circumstances, these documents may also be required:

- COVID-19 Patient Acknowledgement of Positive Case in the Facility
- Third-Party Payer Acknowledgement
- Wellcare Appointment of Representative

We cannot admit the patient without (1) all of these signed documents and (2) proof of guardianship. Please submit all of this material to us as soon as possible.

Fax: 859-298-3344
Email: accesscenter@stepworks.com

Email Disclaimer
Email is not secure, and any email or email attachment could be intercepted or read by a third party.

If you have any questions or concerns, contact us at 1-800-545-9031.

Guardian and Emergency Contact

We may need to contact you or ask for additional forms. Please provide your contact information below to avoid delays in treatment for the patient.

Guardian

Name: _____
Relationship to patient: _____
Best phone number: _____
Email: _____
Emergency phone: _____

Emergency Contact

Please list an emergency contact for the patient in case we cannot reach you. **A general release of information must be completed for the emergency contact listed below.**

Name: _____
Relationship to patient: _____
Best phone number: _____

Are there any extenuating circumstances about you, the patient, or the guardianship? Please let us know:

_____
_____
_____
_____
_____

Important: return proof of guardianship with this form.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

OUR PRIVACY POLICY

Stepworks Recovery Centers, its facilities and subsidiaries, and all associates are committed to providing you with quality behavioral healthcare services. An important part of that commitment is protecting your health information according to applicable law. This notice ("Notice of Privacy Practices") describes your rights and our duties under Federal Law. Protected health information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition; the provision of healthcare services; or the past, present, or future payment for the provision of healthcare services to you.

OUR DUTIES

We are required by law to maintain the privacy of your PHI; provide you with notice of our legal duties and privacy practices with respect to your PHI; and to notify you following a breach of unsecured PHI related to you. We are required to abide by the terms of this Notice of Privacy Practices. This Notice of Privacy Practices is effective as of the date listed on the first page of this Notice of Privacy Practices. This Notice of Privacy Practices will remain in effect until it is revised. We are required to modify this Notice of Privacy Practices when there are material changes to your rights, our duties, or other practices contained herein.

We reserve the right to change our privacy policy and practices and the terms of this Notice of Privacy Practices, consistent with applicable law and our current business processes, at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. Notification of revisions of this Notice of Privacy Practices will be provided as follows:

1. Upon request;
2. Electronically via our website or via other electronic means; and
3. As posted in our place of business.

In addition to the above, we have a duty to respond to your requests (e.g. those corresponding to your rights) in a timely and appropriate manner. We support and value your right to privacy and are committed to maintaining reasonable and appropriate safeguards for your PHI.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by us is protected by Federal law and regulations. Generally, we may not say to a person outside the treatment center that you are a patient of the treatment center, or disclose any information identifying you as an alcohol or drug abuser unless:

1. You consent in writing (as discussed below in "Authorization to Use or Disclose PHI");
2. The disclosure is allowed by a court order (as discussed below in "Uses and Disclosures"); or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation (as discussed below in "Uses and Disclosures").[1]

Violation of the Federal law and regulations by the treatment center is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.[2]

Federal law and regulations do not protect any information about a crime committed by you either at the treatment center or against any person who works for the treatment center or about any threat to commit such a crime (as discussed below in "Uses and Disclosures").

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities (as discussed below in "Uses and Disclosures").

See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations.[3]

USES AND DISCLOSURES

Uses and disclosures of your PHI may be permitted, required, or authorized. The following categories describe various ways that we use and disclose PHI.

Among Stepworks Recovery Centers Personnel. We may use or disclose information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse, provided such communication is: (i) Within the facility; or (ii) Between the facility and other Stepworks Recovery Centers. For example, our staff, including doctors, nurses, and clinicians, will use your PHI to provide your treatment care. Your PHI may be used in connection with billing statements we send you and in connection with tracking charges and credits to your account. Your PHI will be used to check for eligibility for insurance coverage and prepare claims for your insurance company where appropriate. We may use and disclose your PHI to conduct our healthcare business and to perform functions associated with our business activities, including accreditation and licensing.

Secretary of Health and Human Services. We are required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rules.

Business Associates. We may disclose your PHI to Business Associates that are contracted by us to perform services on our behalf which may involve receipt, use or disclose of your PHI. All of our Business Associates must agree to: (i) Protect the privacy of your PHI; (ii) Use and disclose the information only for the purposes for which the Business Associate was engaged; (iii) Be bound by 42 CFR Part 2; and (iv) if necessary, resist in judicial proceedings any efforts to obtain access to patient records except as permitted by law.

Crimes on Premises. We may disclose to law enforcement information that is directly related to the commission of a crime on the premises or against our personnel or to a threat to commit such a crime.[4]

Reports of Suspected Child Abuse and Neglect. We may disclose information required to report under state law incidents of suspected child abuse and neglect to the appropriate state or local authorities. However, we may not disclose the original patient records, including for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect, without consent.[5]

Court Order. We may disclose information required by a court order, provided certain regulatory requirements are met.

Emergency Situations. We may disclose information to medical personnel for the purpose of treating you in an emergency.

Research. We may use and disclose your information for research if certain requirements are met, such as approval by an Institutional Review Board.

Audit and Evaluation Activities. We may disclose your information to persons conducting certain audit and evaluation activities, provided the person agrees to certain restrictions on disclosure of information.

Reporting of Death. We may disclose your information related to cause of death to a public health authority that is authorized to receive such information.

AUTHORIZATION TO USE OR DISCLOSE PHI

Other than as stated above, we will not use or disclose your PHI other than with your written authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your PHI for marketing purposes, or sell your PHI unless you have signed an authorization. If you or your representative authorize us to use or disclose your PHI, you may revoke that authorization in writing at any time to stop future uses or disclosures. We will honor oral revocations upon authenticating your identity until a written revocation is obtained. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

PATIENT/CLIENT RIGHTS

The following are the rights that you have regarding PHI that we maintain about you. Information regarding how to exercise those rights is also provided. Protecting your PHI is an important part of the services we provide you. We want to ensure that you have access to your PHI when you need it and that you clearly understand your rights as described below.

RIGHT TO NOTICE

You have the right to adequate notice of the uses and disclosures of your PHI, and our duties and responsibilities regarding same, as provided for herein. You have the right to request both a paper and electronic copy of this Notice. You may ask us to provide a copy of this Notice at any time. You may obtain this Notice from facility staff or our Privacy Officer.

RIGHT OF ACCESS TO INSPECT AND COPY

You have the right to access, inspect and obtain a copy of your PHI for as long as we maintain it as required by law. This right may be restricted only in certain limited circumstances as dictated by applicable law. All requests for access to your PHI must be made in writing. Under a limited set of circumstances, we may deny your request. Any denial of a request to access will be communicated to you in writing. If you are denied access to your PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by Stepworks Recovery Centers will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the decision made by the designated professional. If you are further denied, you have a right to have a denial reviewed by a licensed third-party healthcare professional (i.e. one not affiliated with us). We will comply with the decision made by the designated professional.

We may charge a reasonable, cost-based fee for the copying and/or mailing process of your request. As to PHI which may be maintained in electronic form and format, you may request a copy to which you are otherwise entitled in that electronic form and format if it is readily producible, but if not, then in any readable form and format as we may agree (e.g. PDF). Your request may also include transmittal directions to another individual or entity.

RIGHT TO AMEND

If you believe the PHI we have about you is incorrect or incomplete, you have the right to request that we amend your PHI for as long as it is maintained by us. The request must be made in writing and you must provide a reason to support the requested amendment. Under certain circumstances we may deny your request to amend, including but not limited to, when the PHI: 1. Was not created by us; 2. Is excluded from access and inspection under applicable law; or 3. Is accurate and complete. If we deny amendment, we will provide the rationale for denial to you in writing. You may write a statement of disagreement if your request is denied. This statement will be maintained as part of your PHI and will be included with any disclosure. If we accept the amendment we will work with you to identify other healthcare stakeholders that require notification and provide the notification.

RIGHT TO REQUEST AN ACCOUNTING OF DISCLOSURES

We are required to create and maintain an accounting (list) of certain disclosures we make of your PHI. You have the right to request a copy of such an accounting during a time period specified by applicable law prior to the date on which the accounting is requested (up to six years). You must make any request for an

accounting in writing. We are not required by law to record certain types of disclosures (such as disclosures made pursuant to an authorization signed by you), and a listing of these disclosures will not be provided. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will notify you of the fee to be charged (if any) at the time of the request.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request restrictions or limitations on how we use and disclose your PHI for treatment, payment, and operations. We are not required to agree to restrictions for treatment, payment, and healthcare operations except in limited circumstances as described below. This request must be in writing. If we do agree to the restriction, we will comply with restriction going forward, unless you take affirmative steps to revoke it or we believe, in our professional judgment, that an emergency warrants circumventing the restriction in order to provide the appropriate care or unless the use or disclosure is otherwise permitted by law. In rare circumstances, we reserve the right to terminate a restriction that we have previously agreed to, but only after providing you notice of termination.

OUT-OF-POCKET PAYMENTS

If you have paid out-of-pocket (or in other words, you or someone besides your health plan has paid for your care) in full for a specific item or service, you have the right to request that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or healthcare operations, and we are required by law to honor that request unless affirmatively terminated by you in writing and when the disclosures are not required by law. This request must be made in writing.

RIGHT TO CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about your PHI and health matters by alternative means or alternative locations. Your request must be made in writing and must specify the alternative means or location. We will accommodate all reasonable requests consistent with our duty to ensure that your PHI is appropriately protected.

RIGHT TO NOTIFICATION OF A BREACH

You have the right to be notified in the event that we (or one of our Business Associates) discover a breach involving unsecured PHI.

RIGHT TO VOICE CONCERNS

You have the right to file a complaint in writing with us or with the U.S. Department of Health and Human Services if you believe we have violated your privacy rights. Any complaints to us should be made in writing to our Privacy Official at the address listed below. **We will not retaliate against you for filing a complaint.**

Questions, Requests for Information, and Complaints

For questions, requests for information, more information about our privacy policy or concerns, please contact us. Our company Privacy Officer can be contacted at:

Stepworks Recovery Centers

Chief Compliance Officer
Nicole Melloan
PO Box 6209
Elizabethtown, KY 42702-6209
nicole@stepworks.com

We support your right to privacy of your Protected Health Information. You will not be retaliated against in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

If you believe your rights have been violated and would like to submit a complaint directly to the U.S. Department of Health & Human Services, then you may submit a formal written complaint to the following address:[6]

U.S. Department of Health & Human Services

Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775
OCRMail@hhs.gov www.hhs.gov

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[1] 42CFR Part 2 2.22b.1.
[2] 42CFR Part 2 2:22b.2
[3] 42CFR Part 2 2:22b.5.
[4] 42CFR Part 2 2:22b.3
[5] 42CFR Part 2 2:22b.4
[6] 42CFR Part 2 2:22b.2

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Acknowledgment of Receipt of Notice of Privacy Practices

I understand that my information is private and confidential. Stepworks Recovery Centers has procedures to protect the privacy and confidentiality of every patient's personal health information. I will assist Stepworks Recovery Centers by following these procedures if I choose to exercise any of my rights as described in the "Notice of Privacy Practices." This acknowledgment will become part of my permanent record.

If I become aware of another patient's private health matters, I will not disclose them to others. I will treat such knowledge as strictly private and confidential.

I understand how Stepworks Recovery Centers may use my patient information, I have read the "Notice of Privacy Practices," and I agree to be treated under the stipulations described.

Patient/Guardian signature: _____ Date: _____ / _____ / _____

Witness: _____ Date: _____ / _____ / _____

Fee Agreement

Stepworks Recovery Centers, LLC ("Stepworks"), a Kentucky limited liability company, and _____ ("Patient"), hereby enter into this Fee Agreement ("Agreement") for Stepworks to provide substance abuse treatment services to the Patient for the fees and under the conditions outlined herein.

Services

- ❑ Substance Abuse Assessment
- ❑ Residential Detox
- ❑ Residential Treatment
- ❑ Partial Hospitalization
- ❑ Intensive Outpatient Treatment
- ❑ Group Therapy
- ❑ Individual Therapy
- ❑ Other (explain):

_____

Estimated Fees[1]

Estimated Total Charges:	
Estimated Insurance Payments:	
Estimated Patient Responsibility:	
Non-Refundable Deposit:	

[1]All fees are *estimates* only. Fees are based on a number of factors, including insurance requirements, allotted days per treatment type, length of patient stay, and insurance utilization and review.

Other Fees

There are some additional charges that the Patient may incur while at Stepworks that are not included in this Fee Agreement. These include but are not limited to: medications, books, toiletry items, drug screens, cancellation fees, and other miscellaneous fees. These charges are hard to estimate and generally not covered under insurance plans. These fees are payable at the time of service. Upon request, an itemized statement may be provided at discharge.

Refund Policy

The Patient acknowledges that the successful treatment of chemical dependency often requires negative consequences for destructive decision-making. Therefore the Patient agrees that premature discharge from residential services will result in forfeiture of any and all funds deposited as part of this agreement. Premature discharge is defined as any discharge occurring prior to the completion of treatment goals. This includes but is not limited to the event in which request for premature discharge is beyond the control of the Patient (e.g. transfer to another facility due to unexpected medical conditions). If a refund is due, and the original payment was made via credit or debit card, the applicable amount of credit/debit card fees paid by Stepworks to process the transaction will be withheld from the refund amount.

Insurance Policy

The Patient agrees to provide information regarding health insurance and other health care benefits to which the Patient may be entitled. The Patient assigns payment(s), if any, from insurance carrier(s)/health benefit plan(s) to Stepworks for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any major medical benefits otherwise payable to the Patient under the terms of the policy, but not to exceed the balance due for services rendered. **The Patient understands that if the Patient's insurance company or health maintenance organization does not consider the services rendered as covered or has not authorized the services, then the Patient will be fully responsible for payment to Stepworks for services rendered.** The Patient also understands and acknowledges that in the case of out-of-plan or out-of- network services, there may be reduced benefits, and the Patient may be required to pay a larger co-pay, co-insurance, or other charges. In the event that the insurance company does not reimburse these services rendered, the Patient acknowledges that the Patient will be responsible for any balance that the insurance company declines to pay.

Stepworks requires the Patient to make payment at the time of service. Prompt payment allows us to control costs and keep our fees to a minimum. Patients with a standard copayment (e.g. $10/$12/$15 per visit) are required to pay it at the time of service. Patients whose co-insurance is based on a percentage of the charge are required to pay an

estimated percentage of their bill at the time of service. Such payment will be applied toward the Patient's ultimate responsibility. If the Patient has a deductible that has not been met, the insurance carrier will apply services to that deductible. Stepworks requires the Patient to pay any deductibles at the time of service.

If the Patient has insurance coverage, Stepworks is glad to help the Patient resolve the maximum allowable benefits and will file the claim(s) for the Patient. If the insurance carrier fails to process the Patient's claim within 45 days of the date of service, the balance becomes the Patient's responsibility. In the event of a problem with insurance, the Patient will assist Stepworks in contacting the insurance carrier. The Patient should be aware that few insurance companies volunteer to cover all medical costs. Stepworks is committed to providing the best treatment to the Patient and charges what is usual and customary. The Patient is responsible for payment regardless of any insurance company's assessment of usual and customary rates, which may not reflect the current standard and cost of care in the area.

By executing this Agreement, the Patient authorizes the release of information to entities for the purpose of satisfying billed charges and/or facilitating utilization review or otherwise complying with obligations of state or federal law. Information which may be released for this purpose includes financial information and protected health information and medical records for services rendered, including records related to treatment for substance abuse. Such information may be released to the Patient's insurance carrier, managed care plan, or other payor, including past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, billing agents, collection agents, our attorneys or insurance companies, the Social Security Administration, the Centers for Medicare and Medicaid, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency.

The Patient agrees to pay all charges for which the Patient may be legally responsible, including but not limited to health insurance deductibles, copayments, and non-covered services. In the event that the Patient's account must be placed with an attorney or collection agency to obtain payment, the Patient agrees to pay reasonable attorney's fees and a collection fee of $50.

The Patient agrees to allow Stepworks to retain copies, imprints, etc., of a credit card or checking account routing number to ensure prompt payment for these services. This authorization is in effect for all future claims until the Patient chooses to revoke it in writing.

Entire Agreement

This Agreement represents the entire agreement between Stepworks and the Patient with respect to the subject

matter hereof. This Agreement supersedes all prior agreements, including but not limited to all prior written and oral statements.

Governing Law

This Agreement and the rights of the parties hereunder shall be governed, interpreted, and enforced in accordance with the laws of the Commonwealth of Kentucky.

Headings

All headings herein are inserted only for convenience and ease of reference and are not to be regarded in the construction or interpretation of any provision of this Agreement.

Severability

If any provision of this Agreement is found to be illegal, invalid, or unenforceable under present or future laws effective during the term of this Agreement, such provision shall be fully severable; and this Agreement shall be construed and enforced as if such illegal, invalid, or unenforceable provision had never been included in this Agreement; however, the remaining provisions of this Agreement shall remain in full force and effect and shall not be affected by the provision in question or by its severance from this Agreement. Furthermore, in lieu of such illegal, invalid, or unenforceable provision, there shall be added to this Agreement a provision as similar in terms to the provision in question as may be possible and legal, valid, and enforceable, and such a revised provision shall be construed and enforced as a valid part of this Agreement.

Arbitration

Any dispute arising out of or in connection with this Agreement, including any matter regarding its existence, validity, or termination, shall be settled by arbitration under the Rules of the American Arbitration Association for Commercial Disputes (the “Rules”). The number of arbitrators shall be one (1) if all parties to the dispute agree on the arbitrator. If there is a disagreement on selection of a sole arbitrator, the number of arbitrators shall then be three (3), with the arbitrators appointed in accordance with the Rules from a panel of arbitrators in Louisville, Kentucky. The place of arbitration shall be Louisville, Kentucky, or such other place as the parties to the dispute shall agree in writing. The arbitration proceedings shall be conducted in the English language, and the arbitral award shall be rendered in writing in the English language stating the reasons for the award. Judgment upon the award rendered by the arbitrator or arbitrators may be entered in any court having jurisdiction thereof and shall be binding on the parties hereto. The costs of arbitration, including reasonable legal fees and costs, shall be borne by either or both parties in whatever proportion as the arbitrator or arbitrators may award.

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Rights of Third-Party Payment Source

This Agreement is entered into among Stepworks and the Patient for the exclusive benefit of Stepworks and the Patient. This Agreement is expressly not intended for the benefit of any other person. Except and only to the extent provided by applicable statute, no third party shall have any rights under this Agreement or any agreement between Stepworks and the Patient. In particular, no family members or other persons who may pay Stepworks on behalf of the Patient for the services provided according to this Agreement shall be entitled to any rights under this Agreement.

Patient Signature: _____ Date: _____/_____/_____

Team Member Signature: _____ Date: _____/_____/_____

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Consent to Assessment and Treatment

I understand that as a patient of Stepworks Recovery Centers, I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

I hereby give consent for assessment, evaluation, treatment, and psychotherapy services provided by Stepworks.

I understand that some sessions with Stepworks physicians, therapists, or other service providers may be conducted via telehealth. Stepworks will provide all of the audio-visual equipment so that you can see and hear your healthcare provider. We use technology that is designed to protect your privacy, and these sessions will be conducted in a private area, however, we cannot guarantee that someone else could not overhear or see your telehealth visit.

I hereby give consent to use telehealth for assessment, evaluation, treatment, and psychotherapy services provided by Stepworks.

I understand that all information shared with the clinicians at Stepworks is confidential and no information will be released without my consent. During the course of treatment at Stepworks, it may be necessary for my therapist to communicate with other providers and staff of Stepworks. Written authorization will not be requested prior to any discussion with Stepworks' providers. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- When there is a risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder and to inform the proper authorities.
- When a valid court order is issued for medical records, the clinician and Stepworks are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provide Stepworks services. All professionals in training are supervised by licensed staff.

I understand that while psychotherapy and/or medication may provide significant benefits, they may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories. Medications may have unwanted side effects.

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Release of Liability

I understand that Stepworks is not responsible for lost or stolen items. I am aware that personal locked spaces are available to me. I understand that I am responsible for my own personal safety, as outlined in the residential rules. I understand that, while Stepworks strives to provide the safest possible environment, my decisions and behaviors affect my safety and sobriety.

I hereby release, waive, and discharge from, and covenant not to sue Stepworks Recovery Centers, its officers, servants, agents, and employees (hereinafter referred to as releases) on account of any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or relating to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, whether caused by the negligence of the releases or otherwise, while I am a patient at Stepworks, or while in, on, or upon the premises where treatment is being conducted, while in transit to or from the premises, or in any place or places connected with Stepworks Recovery Centers.

I am fully aware of risks and hazards connected with being on the premises; and that there may be risks and hazards unknown to me connected with being on the premises; and I hereby elect to voluntarily admit to the facility, to enter upon the above-named premises and engage in activities knowing that conditions may be hazardous, or may become hazardous or dangerous to me and my property, including Team Course activities. I voluntarily assume full responsibility for any risks of loss, property damage, or personal injury, including death, that may be sustained by me, or any loss or damage to property owned by me, as a result of my being a patient at Stepworks Recovery Centers, whether caused by the negligence of releases or otherwise.

I further hereby agree to indemnify and save and hold harmless the releases together or individually, from any loss, liability, damage, or costs they may incur, whether caused by the negligence of any or all of the releases or otherwise.

It is my express intent that this release shall bind the members of my family and spouse if I am alive, and my heirs, assigns, and personal representative if I am deceased, and shall be deemed as a release, waiver, discharge, and covenant to not sue the above-named releases.

Pharmacy Choice

Stepworks uses specific pharmacies at each of its residential locations to ensure the timely delivery of patients' medications. By signing this document, I waive my choice of pharmacy while a patient at Stepworks' residential facility.

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Patient Chores

Each patient in treatment will be afforded the opportunity to practice responsible self-care and self-discipline through the assignment of daily chores. Chore assignments will be posted daily. Patients are responsible for completing chores within the posted time frames. Upon completion of designated chores, patients will initial the chore sheet. Staff will check for proper completion of chores and initial that chores were completed satisfactorily. Each patient will be expected to pick up after themselves in the building and on the grounds.

Dorm areas will be kept tidy. Stepworks will provide patients with adequate storage space for personal property. Patients' personal items must be kept in the storage spaces provided in the dorm areas. Patients may use the top of their nightstand for a clock, radio, books, photos, and study materials but must maintain the area in a tidy fashion. All other items must be stored out of sight.

Community areas are to be free of patients' personal items. Community items, such as games, playing cards, and books, are to be stored in appropriate storage spaces.

Patient items that are found out of place by staff during rounds will be confiscated and placed in the recovery coach office. Patients will be responsible for requesting these items back from staff.

The failure to comply with this policy will be reviewed by the clinical team and may result in the revoking of privileges or other therapeutic intervention as deemed appropriate by the clinical team.

The staff's role in enforcing this policy is one of reinforcing the therapeutic value of self-care, self-discipline, and responsibility.

Residential Rules

Rules of appropriate behavior are common in life and essential to maintaining a safe and therapeutic environment. I hereby agree to abide by the rules listed below and any other rule instituted by Stepworks and/or the clinical team.

- Never discuss, trade, sell, or share medications. This is a serious violation.
- Never bring prohibited items, including drugs and alcohol, into Stepworks. (Read our "What to Bring" document.)
- Attend all groups on time.
- Follow the curfew: 9:00 P. M. Sunday through Thursday, 10:00 P. M. on Fridays and Saturdays. (Doors are locked at these times.)

- Keep your personal area neat: make your bed when you are not sleeping in it, and keep your clothes and personal items put away.
- Pick up after yourself inside and outside the facility.
- Complete chores and dorm duties before 8:00 A. M. (or as scheduled).
- The kitchen is cleaned daily at 9:30 P. M. Wash and put away your dishes when eating outside of meal times.
- Never enter the opposite gender's dorm area.
- Do not bring visitors into the dorm area.
- Never enter staff areas unaccompanied.
- Do not eat or drink in dorm areas. (You may have a glass of water at your bedside.)
- Do not lay on or put your feet on the furniture.
- Staff will search and approve any items brought by visitors.
- Romantic, aggressive, or violent conduct will result in discharge.
- Do not smoke in the facility. Stepworks provides a designated outdoor smoking area.
- Always wear appropriate shoes and clothes: no house shoes or pajamas outside of the dorm area; no female cleavage or sagging pants; no cut-off shirts that expose the chest or abdomen; no hats, hoods, or sunglasses indoors.
- Stepworks reserves the right to change these residential rules.

Consent to Video Surveillance and Recording

I understand that Stepworks Recovery Centers utilizes video surveillance and recording in the following places & activities:

- All patient admissions
- Most public areas
- Clinical team rounds
- Group therapy sessions

The purpose of this surveillance is to support the security and integrity of our facility and programs as well as support quality improvement activities at Stepworks. This surveillance may be recorded and stored at the sole discretion of Stepworks. Any recordings are not considered part of your health record and will not be released as part of any records release.

In the event of alleged rule-breaking, video recordings may be used to properly assess actions and potential consequences.

Under no circumstances will any recordings be sold, distributed, displayed, or used for any purpose other than explicitly described in this document or as required by law.

By signing this document and consenting to the items herein, I hereby specifically acknowledge and approve the use of video surveillance and recording and release any personal rights to these recordings.

HIV & Hepatitis Education

I have been offered materials regarding HIV & hepatitis infection.

Patient Rights

As a patient, you have the right to:

- Be treated with consideration, respect, and dignity.
- Not be discriminated against in determining eligibility for treatment.
- Not be treated in any way constituting abuse, harassment, financial exploitation, retaliation, humiliation, or neglect.
- Give informed consent to receive a service. (Adult patients shall sign an informed consent to receive a service. If the patient has a legal guardian, then the legal guardian shall sign the consent.)
- Have informed consent or refusal or expression of choice regarding releases of information, concurrent services, and composition of the service delivery team.
- Have input into your treatment and case management plans and be informed of their content.
- Have individualized treatment.
- File a grievance, recommendation, or opinion regarding the service you receive without fear of retaliation.
- Give informed consent regarding participation in research studies with the exception of a juvenile whose parent or guardian shall give informed consent.
- Confidentiality in accordance with state and/or federal laws.
- Request a written statement of the charge for a service and be informed of the policy for the assessment and payment of fees.
- Be informed of the rules of patient conduct including the consequences for the use of alcohol and other drugs or other infractions that may result in disciplinary action or discharge.
- Review your patient record.
- Receive one free copy of your record.
- Be given the opportunity to vote in a political election.
- Be given reasonable accommodations to afford privacy in bathing and toileting.

- Obtain access or referral to appropriate legal representation, self-help support services, and advocacy support services.
- Consult with a member of clergy, private attorney, or physician retained by you.
- Receive visitors.
- Send and receive communications by mail, telephone, and telegraph, and that these communications shall not be censored or read without consent.

If you feel as though your patient rights have been violated or you have a complaint, Stepworks Recovery Centers will employ every reasonable effort to resolve your complaint. If you feel as though your complaint is not adequately resolved, you may contact the Cabinet for Health Services ombudsman at 1-800-372-2973 and/or file a complaint form, which can be found on the bulletin board.

I have read and fully understand my rights, and Stepworks staff have answered any questions that I may have had.

In signing this consent, I acknowledge that:

- **I have read the foregoing consent, understand it, and sign it voluntarily as my own free act and deed;**
- **No oral representation, statements, or inducements, apart from the foregoing written agreement, have been made;**
- **I am at least 18 years of age and fully competent; and I execute this release for full, adequate, and complete consideration, fully intending to be bound by the same.**

_____ _____

Patient/Guardian signature Date

_____ _____

Witness Date

Authorization for Release of Information to Treating Providers

From:
Stepworks Recovery Centers

To:
All treating providers

Patient Name: _____

Social Security #: _____ Date of Birth: _____ / _____ / _____

I hereby authorize Stepworks Recovery Centers to release any information to **any confirmed treatment provider**. I understand that any information released will be limited to pertinent clinical information only. I hereby authorize the release of information to: hospitals, physicians, physician offices, nurse practitioners, physician assistants, nurses, health departments, laboratories, radiology providers.

PROHIBITION OF DISCLOSURE

This information has been disclosed to you for records protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug client.

Patient/Guardian signature: _____ Date: _____ / _____ / _____

stepworks

COVID-19 Positive Patient Information Sheet

We are so sorry to hear that you have tested positive for COVID-19. We want to ensure that you continue to receive treatment while you recover from the virus. This form will inform you of Stepworks' COVID-19 protocols and when to seek medical attention.

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

County of residence: _____

Are you vaccinated? ☐ No ☐ Yes, fully vaccinated ☐ Yes, partially vaccinated

What to Expect

- COVID-19 is a highly contagious respiratory virus. Stepworks must take precautions to keep other patients and our team safe. Therefore, you will be asked to quarantine, wear a surgical mask, and social distance.
- If your symptoms are mild, you can still participate in groups and therapy provided you follow masking and social distancing guidelines.
- We can provide you medications for your symptoms, so be sure to tell us if you are feeling poorly.
- We will take your vitals frequently, including a pulse oximetry test which measures your blood oxygen levels. If your oxygen levels dip to a concerning level, we may send you to a local emergency room to be evaluated.
- If you experience a worsening shortness of breath, shortness of breath under exertion, or the inability to speak without shortness of breath, please tell a Stepworks team member immediately.
- If you are scheduled to discharge in the next ten days, you may be considered for an extended stay until your quarantine is complete. We can make exceptions if you live alone or with family who can accommodate quarantine requirements.
- We cannot discharge you to a sober living environment or community facility until you have served your quarantine period.
- If you wish to isolate at home during this quarantine period, you may choose to leave Stepworks. After you have recovered from COVID-19, you can call us and be reassessed for treatment, but we cannot make any guarantees about placement.

I agree to the following guidelines:

- I will use hand sanitizer and wash my hands frequently, including after using the restroom, after coughing/sneezing, after blowing my nose, before eating, before taking medication, and before/after smoking.
- I will wear a surgical mask at all times except when I am eating, drinking, smoking, or alone in a room (until the facility medical director gives permission for this to be discontinued).
- I will keep at least a six foot distance from other patients and Stepworks team members.
- I will keep twelve feet of separation while on smoke breaks.
- I will eat separately from other patients, and I will not assist with food preparation.
- If my symptoms are mild, I can attend groups, but I must wear my mask and stay socially distanced from others.
- I agree to comply with quarantine procedures for ten days from either the start of my symptoms or the date of my positive COVID-19 test.
- Failure to follow the above guidelines may result in an administrative discharge from Stepworks.
- All Stepworks COVID-19 protocols and guidelines have been explained to me; I have had the opportunity to ask questions; I understand these guidelines and will comply with them.

Patient Signature: _____ Date: ____ / ____ / ____

Team Member Signature: _____ Date: ____ / ____ / ____

stepworks
recovery centers

Special Event Authorization for Release of Information

I understand that there will be events held at Stepworks where I may come in contact with the general public. These events may include open houses, the tours of the facility, or special interest interviews held by the media.

I hereby authorize Stepworks to release the following general information:

- ❏ My presence at Stepworks
- ❏ Guest questions
- ❏ Other (describe):

Note: All clinical data will be excluded.

I understand that I can revoke my consent at any time except when disclosure has already taken place. Otherwise this consent will expire on _____or 90 days from the date signed.

Patient Signature *Date*

Witness Signature *Date*

I decline any special event authorization (patient) *Date*

Witness Signature *Date*

Media Release Form

I hereby grant **Stepworks Recovery Centers, LLC** ("the company") permission to the rights of my image, likeness, and sound of my voice as recorded on audio or video without payment or any other consideration for use by the company. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or voice recording. By signing this release, I understand this permission signifies that all content may be electronically displayed via the Internet (e.g. stepworks.com, Facebook, Twitter, Instagram, etc.) or other settings. There is no time limit on the validity of this release, nor is there any geographic limitation on where these materials may be distributed.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name: _____

Street Address: _____

City: _____

Zip Code: _____

Phone: _____

Email: _____

Signature: _____

Date: _____

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

Signature: _____

Date: _____

Stepworks Recovery Centers, LLC
P.O. Box 6209, Elizabethtown, KY 42702
http://stepworks.com
800-545-9031

stepworks

General Authorization for Release of Information

From:
Stepworks Recovery Centers

To:
Name: _____
Address: _____
City State Zip
Phone number: _____
Relationship to patient: _____

Patient Name: _____

Social Security #: _____ Date of Birth: _____ / _____ / _____

Type of information to be released (check all that apply):

- ☐ Discharge Summary
- ☐ Lab Results (except HIV/hepatitis)
- ☐ Biopsychosocial Evaluation/Psychotherapy notes
- ☐ HIV and/or hepatitis results
- ☐ Progress Notes
- ☐ Medical Data
- ☐ Treatment Plan
- ☐ Website
- ☐ Other (specify) _____

I hereby authorize **Stepworks Recovery Centers** to release the indicated information to the individuals listed above. Faxed information will be limited to pertinent clinical information only. I understand that I can revoke my consent at any time except when disclosure has already taken place, in which case consent will expire on _____ _____ or 90 days from the date on which this form was signed.

The purpose for this release is:

- ☐ Legal Circumstances
- ☐ Vocational Rehabilitation
- ☐ Referral
- ☐ Continuity of Care
- ☐ Disability Determination
- ☐ Insurance Purposes
- ☐ Placement/ Disposition
- ☐ Other (specify) _____

PROHIBITION OF DISCLOSURE

This information has been disclosed to you for records protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Patient/Guardian signature: _____ Date: _____ / _____ / _____