Assisted Recovery Centers of America, LLC

Consent for Treatment

I, ____ (patient's name), voluntarily request to receive medical treatment from Assisted Recovery Centers of America. I understand that this consent is for any of the services or programs which are provided by Assisted Recovery Centers of America. I consent to the administration of treatment deemed necessary by my physician(s) who attend me, their associates, employees of ARCA, and other healthcare professionals responsible for my care. I understand that care may consist of a physical exam, medical assessment, nursing and counseling/social work assessments, laboratory tests, treatment planning, individual and group treatments, discharge planning, care coordination, as well as prescribing and administration of medications.

The purpose of my participation in treatment has been described to me. I understand that the specific care proposed for me, including the benefits and risks, may be further discussed with me by my physician, nursing or counseling staff. I agree to attend and participate in all scheduled treatment activities as described in my treatment/services plan. I understand that I have the right to ask for clarification of services and interventions and to decline the services and interventions at any time. I acknowledge that no guarantees have been made to me as to the effect of treatment or prognosis of my condition.

I understand that in the event of an emergency I may be transferred to a hospital or emergency medical facility better equipped than ARCA to provide emergency and/or comprehensive medical care.

Assignment of Benefits and Release of Information

I understand that my express consent is required to release any health care information relating to testing, diagnosis, medications and or treatment for psychiatric disorders or drug/alcohol abuse/dependence. I give my consent for ARCA to release medical including information for psychiatric and or drug/alcohol abuse or dependence and other relevant information as required by my insurance company to process medical billing. I authorize direct payment to ARCA of all insurance benefits applicable to this episode of care which are now or which shall become due and payable to me. In addition, I authorize direct payment to the company of all insurance benefits applicable to medical services rendered by physicians for whom ARCA is authorized to charge and bill. I understand that ARCA works with physicians who are independent contractors. I consent to the assignment of benefits and release of information stated above as it may pertain to those independent contractors.

Financial Responsibility

In accordance with the above terms in consideration of the service rendered to the patient designated herein, I guarantee and agree to pay ARCA charges for those services rendered, including any deductibles, coinsurance or amounts not paid by my

Patient Label

Assisted Recovery Centers of America, LLC

insurance plan, health service plan or health maintenance organization. By signing this document, the patient and guarantors acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization), or other insurance provider.

Release of Information

I acknowledge that there are instances when ARCA must release information concerning my care, including information related to my mental health, substance abuse, HIV and/or AIDS, including copies of my medical records, to certain individuals or entities who are involved in my care, payment for my care, and other activities related to my care. Information may be released to: any healthcare provider within ARCA who is participating in providing my care or supervision of those who are providing my care, any federal, state or other governmental or quasi-governmental agencies or other such parties as required by law for the purposes of reporting, any person or entity participating in quality studies, utilization review or similar studies of the care rendered by the Organization. Also, any partner/referral agencies with signed MoU's, for the purpose of continuity of care.

I understand that my failure to comply with any of the above conditions will be regarded by the staff as my request for immediate discharge.

I acknowledge that I been provided a copy of ARCA's Notice of Privacy Practices and a copy of the Patient Rights and Responsibilities.

Patient Name (Print): ______________________ Patient DOB: __________

Patient Signature: ______________________ Date: __________

Staff Witness Name: ______________________

Staff Signature: ______________________ Date: __________

Patient Label

Assisted Recovery Centers of America, LLC

PATIENT INFORMATION

Name: ____________________

Name you prefer to be called: ____________________

Date of birth: __________ SSN: __________ Gender: Male Female

Current address: ____________________

City: __________ State: __________ ZIP Code: __________

Cell Phone: __________ May we leave a message at this number? __________

Home Phone: __________ May we leave a message at this number? __________

Alternate Phone: __________ May we leave a message at this number? __________

Marital Status: __________ Name of Spouse: __________

EMERGENCY CONTACT INFORMATION

Name: ____________________ Relationship: __________

Current address: ____________________

City: __________ State: __________ ZIP Code: __________

Cell Phone: __________ May we leave a message at this number? __________

Alternate Phone: __________ May we leave a message at this number? __________

GENERAL INFORMATION

Referred by: ____________________ Phone Number: __________

Primary Care Physician: ____________________ Phone Number: __________

Primary Language: ____________________

List all Medication Allergies: ____________________

Do you have any visual, auditory or other forms of disability that affect your daily living? Yes No

If Yes, please explain: ____________________

FOR OFFICE USE ONLY

OPI: ETOH: BZO: POLY: Other:

Patient Label

Assisted Recovery Centers of America, LLC

INSURANCE INFORMATION

PRIMARY INSURANCE

Policyholder's Name: ______________________

Patient's Relationship to Policyholder: ______________________

Policyholder's Address (if different from patient's):

Policyholder's Social Security Number: ______________________

Policyholder's Date of Birth: ______________________

Employer Holding Insurance Policy: ______________________

Employer's address: ______________________

City: ____________ State: ____________ ZIP Code: ____________

Insurance Company: ______________ Insurance Phone: ____________

Plan Name: ______________________

Enrollment Date: ID #: Group #:

SECONDARY INSURANCE ☐ I acknowledge that I do not have a secondary insurance ______

Policyholder's Name: ______________________

Patient's Relationship to Policyholder: ______________________

Policyholder's Address (if different from patient's): ______________________

Policyholder's Social Security Number: ______________________

Policyholder's Date of Birth: ______________________

Employer Holding Insurance Policy: ______________________

Employer's address: ______________________

City: ____________ State: ____________ ZIP Code: ____________

Insurance Company: ______________ Insurance Phone: ____________

Plan Name:

Enrollment Date: ID #: Group #:

I understand that billing my insurance company is an additional service being provided and that it is my responsibility to provide complete and accurate information to aid the billing process. It is my responsibility to keep ARCA aware of any changes or modifications to my insurance coverage. Use of this billing service does not remove my responsibility for any or all changes incurred in treatment.

______________________ ______________________ ________

Patient or Responsible Party's Signature Print Name Date

Patient Label

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I the patient, certify that I have read, understand, and received a copy of the Notice of Privacy Practices form.

______________________	______________________
(Print Name)	(Signature)
______________________	______________________
(Witness Name)	(Witness Signature)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

____

Patient Label

ARCA

ARCA Assisted Recovery Centers of America, LLC

Release of Information

Assisted Recovery Centers of America, LLC

I, ____ (patient or guardian), authorize the treatment team of the Assisted Recovery Centers of America (hereinafter referred to as "ARCA"), its employees or agents to release specified confidential medical, psychiatric, substance abuse/dependence, HIV/AIDS test results or diagnosis, and/or information obtained in the diagnosis and treatment at the organization to the below indicated persons/agencies and for the stated reasons. I understand that this authorization extends to all or any part of the records/information and I understand that ARCA will not condition treatment on whether this authorization is signed. Unless expressly stated by the patient/guardian, release of information is authorized from the date of signature through 30 days' post discharge. The patient/guardian may revoke the release at any time by notifying the Organization in writing to the address listed on the bottom of this form. Such revocation will not have any effect on any actions that ARCA took before receiving the revocation.

ARCA asks that you consider giving release for coordination with: Primary care physician, Community psychiatrist, Community therapist, Family members, Pharmacy, PO, and DFS/DCFS.

Name/Agency	Relationship	Address and Phone Number	Purpose	Information to use or disclose
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ______________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ________________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ______________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ________________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ______________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ________________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ______________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ________________

Patient Label

Release of Information

Assisted Recovery Centers of America, LLC

Name/Agency	Relationship	Address and Phone Number	Purpose	Information to use or disclose
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ____________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ______________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ____________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ______________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ____________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ______________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ____________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ______________

By signing this, Release of Information, you are in agreement with the terms and conditions of any MoU that has been signed and agreed upon by any partner/referral agency and Assisted Recovery Centers of America, LLC for the purpose of continuity of care.

Patient Name (Print): ______________________________ Patient DOB: _____________

Patient Signature: ____________________________________ Date: _____________

Staff Witness Name: ____

Staff Signature: ____________________________________ Date: _____________

Patient Label

Patient and Family Medical History

PATIENT INFORMATION

Name ______________________ SS# ______________________ Date ______________

Address ____

Home Phone ____________________ Cell Phone __________________ Date of Birth __________________

HOSPITALIZATION/SURGERY

Dates	Reason for Hospitalization

DRUG HISTORY (Please MARK N/A if never used)

Drug/Substance	Age at 1st Use	How Long Used	Last Date Used	Reason For Use
Alcohol				
Tobacco				
Marijuana				
Opiates (Heroin)				
Cocaine				
Benzo's (Xanax)				
Methamphetamines				
Other				

MEDICATION HISTORY

Medication	Dosage	Times/Day	Date Started/Ended	Reason For Use

DRUG ALLERGIES: ____

____

(If you require additional space to provide any information on this page or the next, please use the reverse side of the page and notify the nurse or physician that you have included additional information)

INDIVIDUAL MEDICAL HISTORY

___ Ringing In Ear
___ Ear Infections
___ Dizziness/Fainting
___ Failing Vision
___ Eye Infections
___ Nose Bleeds
___ Sinus Trouble
___ Sore Throats
___ Hay fever/Allergies
___ Pneumonia
___ Bronchitis
___ Asthma/Wheezing
___ Chest Pain
___ High Blood Pressure
___ Heart Murmur
___ Gall Bladder Trouble
___ Jaundice/Hepatitis
___ Change in Bowels
___ Diarrhea
___ Constipation
___ Diverticulitis
___ Crohn's/Colitis
___ Bloody/Tarry Stools
___ Hemorrhoids
___ Hernia
___ Urine Infections
___ Blood in Urine
___ Overnight Urination
___ Painful Urination
___ Uncontrolled Urination
___ Kidney Stones
___ Venereal Disease
___ Tremor/Hands Shaking
___ Muscle Weakness
___ Numbness/Tingling
___ Headaches-Frequent
___ Arthritis/Rheumatism
___ Osteoporosis
___ Recurrent Back Pain
___ Bone Fracture/Joint Injury
___ Gout
___ Foot Pain
___ Cold Numb Feet
___ Rashes
___ Hives
___ Psoriasis
___ Eczema
___ Nervousness
___ Anxiety
___ Depression
___ Memory Loss
___ Excessive Moodiness
___ Sleeping Problems
___ Problems with Eating

FAMILY MEDICAL HISTORY

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism						
Asthma						
Bleeding Disorder						
Cancer						
Diabetes						
Glaucoma						
Epilepsy/Convulsions						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Migraine						
Osteoporosis						
Stroke						
Thyroid						
Other						

Female patients– Please Complete

Pregnant ____Yes ____ No
Planning a Pregnancy ____ Yes ____ No
Number of Pregnancies:
____ Pregnancies ____ Abortions
____ Miscarriages ____ Live Births
Menstrual Flow:
____ Regular ____ Irregular _____ Pain/Cramps
____ Pain/Bleeding During or After Sex

Date of Last Pap test ________________
Normal or Abnormal (Circle One)
Date of 1st Day of Last Period ______________
Birth Control Method ___________________
Menopause: Yes or No (Circle One)
Date of Last Mammogram ________________
Normal or Abnormal (Circle One)

TEDS

NAME: ______________________________________ **DATE:** ___________

HAVE YOU EVER FELT THE NEED TO BET MORE AND MORE MONEY? YES / NO

HAVE YOU HAD TO LIE TO PEOPLE IMPORTANT TO YOU ABOUT HOW MUCH YOU GAMBLE? YES / NO

HOW IMPORTANT TO YOU NOW IS TREATMENT FOR ALCOHOL PROBLEMS

NOT AT ALL / SLIGHTLY / MODERATELY / CONSIDERABLY / EXTREMELY

HOW IMPORTANT FOR YOU NOW IS TREATMENT FOR DRUG PROBLEMS

NOT AT ALL / SLIGHTLY / MODERATELY / CONSIDERABLY / EXTREMELY

HOW IMPORTANT TO YOU NOW IS TREATMENT FOR PSYCHOLOGICAL PROBLEMS?

NOT AT ALL / SLIGHTLY / MODERATELY / CONSIDERABLY / EXTREMELY

VETERAN STATUS

YES / NO

LIVING ARRANGEMENT

ALONE/ WITH FAMILY/ WITH UNRELATED PERSON/ WITH TRANSITIONAL / WITH PARENT OR SIBLINGS/ WITH OTHER/ WITH SPOUSE ONLY

MARITAL STATUS

NEVER MARRIED/ MARRIED/ WIDOWED/ DIVORCED/ SEPARATED/ REMARRIED/ COMMON LAW/ LIVING AS MARRIED

NUMBER OF CHILDREN IN YOUR CARE ____________

NUMBER OF CHILDREN REMOVED FROM CUSTODY OR IN DFS CUSTODY __________

LEGAL STATUS

NONE / PROBATION/ PAROLE/ AWAITING DISPOSITION/ INCACERATED

CURRENTLY PREGNANT (IF APPLICABLE) YES / NO

TEDS

NUMBER OF ARRESTS IN THE PAST 30 DAYS ____________

NUMBER OF LIFETIME DUI ARRESTS ______________

EDUCATION (CIRCLE HIGHEST COMPLETED)

KINDERGARTEN/ 1ST GRADE/ 2ND GRADE/ 3RD GRADE/ 4TH GRADE/ 5TH GRADE/ 6TH GRADE/ 7TH GRADE/ 8TH GRADE/ 9TH GRADE/ 10TH GRADE/ 11TH GRADE/ 12TH GRADE

TECH EDUCATION IN LIEU OF HIGH SCHOOL

G.E.D.

TECH EDUCATION IN ADDITION TO HIGH SCHOOL

1ST YEAR COLLEGE/ 2ND YEAR COLLEGE/ 3RD YEAR COLLEGE/ 4TH YEAR COLLEGE

GRADUATE COLLEGE/ 1 YEAR GRADUATE/ MASTER DEGREE/ 3RD YEAR GRADUATE

SPECIAL EDUCATION (CIRCLE ALL THAT APPLY)

NO SPECIAL EDUCATION / BEHAVIOR DISORDERED CLASSROOM / EDUCABLE MENTAL RETARDATION / ELEMENTARY AND SECONDARY SPECIAL EDUCATION / LEARNING DISABLED CLASSROOM / REMEDIAL READING/ RESOURCE ROOM / SPECIAL EDUCATION (UNSPECIFIED) / SPECIAL EDUCATION TESTING SUGGESTED/ SPECIAL SCHOOL / SPEECH THERAPY / TRAINABLE MENTAL RETARDATION

ENROLLED IN SCHOOL/JOB TRAINING YES / NO

EMPLOYMENT STATUS

EMPLOYED-FULLTIME (35+ HOURS/WEEK) / EMPLOYED-PART TIME (<35 HOURS/WEEK) / SHELTERED WORKSHOP / SUPPORTED EMPLOYMENT / UNEMPLOYED–SOUGHT LAST 30 OR ON LAYOFF / NOT IN WORKFORCE-HOMEMAKER / NOT IN WORKFORCE-STUDENT (ACADEMIC OR VOCATIONAL) / NOT IN WORKFORCE-RETIRED / NOT IN WORKFORCE-DISABLED / NOT IN WORKFORCE-OTHER

OCCUPATION

CLERICAL WORKER/ CRAFTSMEN / LABORERS / MANAGERS, OFFICIALS, PROPRIETORS / MILITARY SERVICE / OPERATIVE (MECHANICAL INDUSTRY) / OTHER / PROFESSIONAL / SALES WORKERS / SERVICES & HOUSEHOLD

TEDS

INCOME SOURCE

ALIMONY / CHILD SUPPORT / DISABILITY / EMPLOYMENT / FAMILY OR FRIENDS / ILLEGAL / MILITARY / NONE / OTHER / PUBLIC ASSISTANCE-STATE / RETIREMENT / SSA / SSDI / SSF / UNEARNED INCOME / UNEMPLOYMENT / VA / WORK COMP

WEEKLY INCOME

$1-$49

$50-$99

$100-$149

$150- $199

$200-$299

$300-$499

$500 AND OVER

HOUSEHOLD MONTHLY INCOME: $____________________

PUBLIC ASSISTANCE (CIRCLE ALL THAT APPLY)

FOOD STAMPS

JOB OPPORTUNITIES AND BASIC SKILLS TRAINING

LEGAL SERVICES FOR THE POOR

MEDICAID

MEDICARE

PSYCHIATRIC SERVICES

PUBLIC HOUSING

SOCIAL SECURITY DISABILITY BENEFITS

SUBSTANCE ABUSE TREATMENT ASSISTANCE

UNEMPLOYMENT COMPENSATION

VETERAN COMPENSATION

VETERAN PENSIONS

WORKER'S COMPENSATION

TEDS

	Substance Abused (eg: heroin, cocaine, marijuana, etc)	Route of administration (eg: IV, snorting , etc)	Frequency of use in past 30 days	Age of first use
1				
2				
3				

Did you attend a prior detox program? Yes / No

If yes, how many have you attended :___________________

Did you attend a prior residential or inpatient program? Yes / No

If yes, how many have you attended :___________________

Did you attend a prior outpatient program? Yes / No

If yes, how many have you attended :___________________

Primary source of payment

self pay / blue cross blue shield / medicaid / other gov / workers compensation / other insurance / no charge / other

How many days have you attended a self-help program in the last 30 days?

____

Are you currently taking any medications for treatment of addiction?

If yes states select from the following list:

none / naltrexone / buprenorphine / disulfiram / naloxone / suboxone / tranquilizers (valium, librium, etc) / vivitrol / campral / anti-depressants / methadone

TEDS

CIRCLE YOUR PRIMARY HEALTH INSURANCE PROVIDER

NONE / BLUECROSS BLUESHIELD / HEALTH MAINTENANCE ORGANIZATION (HMO) / MEDICARE / MEDICARE / OTHER PRIVATE INSURANCE / OTHER (TRICARE, CHAMPUS)

DO YOU HAVE A DEVELOPMENTAL PROBLEM? YES / NO

DO YOU HAVE A PSYCHOLOGICAL PROBLEM? YES / NO

HAVE YOU USED TOBACCO IN THE LAST 30 DAYS?

YES / NO

ARCA

Assisted Recovery Centers of America, LLC

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

I. Our Privacy and Confidentiality Obligations

- We are required by law to maintain the privacy and confidentiality of information about your health, health care, and payment for services related to your health (referred to in this notice as "protected health information"), and to provide you with this notice of our legal duties and privacy practices with respect to your protected health information. When we use, or disclose this information, we are required to abide by the terms of this notice (or other notice in effect at the time of the use or disclosure).
- **Protected Health Information in connection with alcohol or drug services:** 42 CFR Part 2 protects your health information if you are applying or receiving treatment services for alcohol or drugs. This includes protecting diagnosis, treatment, or referrals related to alcohol or drug treatment. Generally, if you are applying for or receiving services for drugs or alcohol, we may not acknowledge to a person outside of ARCA that you are receiving services from our program, except under certain circumstances that are listed in this notice.
- **All Protected Health Information, including alcohol or drug services:** the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations (45 CFR Parts 160 and 164), also protect your health information whether or not you are applying for or receiving services for drugs or alcohol. Generally, if you are receiving services that are not related to alcohol or drugs, the laws regulating disclosure of protected health information differ slightly and is less restrictive. Since our treatment at ARCA is specifically for alcohol or drugs, we follow the stricter rules, as stated in 42CFR, which also satisfies HIPAA standards.

II. Uses and Disclosures With Your Authorization: All Protected Health Information

- Generally, we may use or disclose your protected health information when you give your authorization to do so in writing on a form that specifically meets the requirements of laws and regulations that apply.
- There are some exceptions and special rules that allow for uses and disclosures without your authorization or consent. They are listed in this notice.
- You may revoke your authorization except to the extent that we have already taken action upon the authorization. If you are currently receiving care and wish to revoke your authorization, you will need to deliver a written statement to a ARCA staff member. If you wish to revoke authorization after discharging, you can send us a written notice of your revocation to 6651 Chippewa, Suite 224, Saint Louis, Missouri, 63109.

III. Uses and Disclosures Without Your Authorization: All Protected Health Information

- Even when you have not given your written authorization, we may use and disclose information under the circumstances listed below. This list applies to all protected health information, including the information we get when you are applying for or receiving services for drugs or alcohol.
  i. Treatment: We may use or disclose your protected health information for treatment purposes among staff at ARCA. Treatment includes diagnosis, treatment and other services, including discharge planning. For example, therapists may disclose your health information to each other or to nursing staff to coordinate your treatment, improve treatment, or discuss treatment alternatives.
  ii. Health Care Operations: We may use or disclose your protected health information for the purposes of health care operations that include internal administration and planning and various activities that improve the quality and effectiveness of care. For example, we may use information about your care to internally evaluate the quality and competence of our staff. In any case, ARCA staff would continue to maintain your privacy and confidentiality as a person who received services at ARCA.
  iii. Medical Emergencies: We may disclose your protected health information to medical personnel to the extent necessary to ensure your safety in a medical emergency (as defined by 42 CFR part 2).
  iv. Judicial and Administrative Proceedings: We may disclose your protected health information in response to a court order that meets the requirements of federal regulations, 42 CFR Part 2 concerning Confidentiality of Alcohol and Drug Abuse Patient Records.
  v. Commission of a Crime on Premises or against ARCA Staff or other building staff: We may disclose your protected health information to the police or other law enforcement officials if you commit a crime on the premises or against staff, or if you threaten to do so.
  vi. Child Abuse or Neglect, or Elder Abuse: We may disclose your protected health information for the purpose of reporting child or elder abuse and neglect to the appropriate authorities for abuse reporting.
  vii. Duty to Warn: When the program learns that a patient has made a specific threat of serious physical harm to another specific person or the public, and disclosure is otherwise required under statute and/or common law, the program will carefully consider appropriate options that would permit disclosure.

Assisted Recovery Centers of America, LLC

viii. Audit and Evaluation Activities: We may disclose protected health information to those who perform audits or evaluation activities for certain health oversight agencies, e.g. state licensure or certification agencies, the Joint Commission on Accreditation of Health Care Organizations, which oversees the health care system and ensures compliance with regulations and standards.

IV. Your Individual Rights Regarding Your Protected Health Information

- Right to Receive Confidential Communications
- Right to Request Restrictions: You may request additional restrictions on our use and disclosure of protected health information for treatment, payment and health care operations. While we consider requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions and you are currently receiving services, please notify your therapist or the Assistant Clinical Director. Once you are no longer receiving services, you may contact us in writing to request restrictions. We will send you a written response.
- Right to Inspect and Copy Your Health Information: You may request access to your clinical file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records and you are currently receiving services, please ask your counselor or therapist for the records. Once you are no longer receiving services, you can contact ARCA directly in writing. If you request copies, there will be a charge for each page copied and you will be told the cost prior to the copies being made.
- Right to Amend your Records: You have the right to request that we amend protected health information maintained in your clinical file or billing records. If you desire to amend your records and you are currently receiving services, please contact your therapist or counselor. Once you are no longer receiving services, you may request an amendment to your records in writing. Under certain circumstances, ARCA has the right to deny your request to amend your records and will notify you of this denial as provided in the HIPAA regulations. If your requested amendment to your records is accepted, a copy of your amendment will become a permanent part of the medical record. When we "amend" a record, we may append information to the original record, as opposed to physically removing or changing the original record. If your requested amendment is denied, you will be informed of your right to have a brief statement of disagreement placed in your medical records.
- Right to Receive Accounting of Disclosures: Upon request, you may obtain a list of instances that we have disclosed your protected health information other than when you gave written authorization OR those related to your treatment and payment for services, or our health care operations. The accounting will apply only to covered disclosures prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a 12 month period, there will be a charge. You will be told the cost prior to the request being filled.
- Right to Receive a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this notice.
- For Further Information and Complaints: I you desire further information about your privacy and confidentiality rights, you may contact the ARCA Executive Director at (314) 645-6840 ext. 3757. You may call this number if you are concerned that we have violated your privacy rights, if you disagree with a decision that we made about access to your protected health information, or if you wish to complain about our breach notification process. You may also file a written complaint with the Secretary of the United States Department of Health and Human Services. Upon request, we will provide you with the correct address. We will not retaliate against you if you file a complaint.

- Violation of federal law and regulations on Confidentiality of Alcohol and Drug Abuse Patient Records is a crime and suspected violations of 42 CFR Part 2 may be reported to the United States Attorney in the district where the violation occurs.

V. Effective Date and Duration of This Notice

- Effective Date: May 20, 2013
- Right to Change Terms of This Notice: We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective to all protected health information that we maintain, including any information created or received prior to issuing the new notice. If we change this notice, we will post the new notice in public areas at ARCA and on our website at arcamidwest.com. You may obtain any new notice by contacting the ARCA Executive Director, Suneal Menzies, at (314) 645-6840, ext. 3757.

Patient Label