BayPointe Hospital Admission Paperwork Fax Cover Sheet

Admission Paperwork Instructions

- **Completed Admission Paperwork** must include:
    1. **Legal guardian initials and signatures** on all appropriate spaces in the included paperwork
    2. Copy of **legal guardian's photo ID**
    3. Copy of **patient's insurance information** (front and back)
- Please fax completed paperwork and photocopies to **866-357-1154** or securely email completed paperwork and photocopies to **ManagedCare@altapointe.org**

Confirmation of Admission Paperwork

- A **BayPointe Admissions Clerk** will contact referring hospital once this paperwork has been received and confirmed to be completed accurately.
- Please **do not transport patient** until BayPointe has confirmed this with the referring hospital.

Referring Hospital: _____

Contact Name: _____ Contact Number: _____

BayPointe Hospital | 5800 Southland Drive, Mobile, AL 36693 | www.BayPointeHospital.org
Phone: (251) 661-0153 | Referrals/Access: (251) 450-2211

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ALTAPOINTE HEALTH
STATEMENT OF UNDERSTANDING AND CONSENTS

PATIENT NAME: _____

Review and initial each applicable area:

All Programs

_____ **Treatment/ Psychiatric Care**: I hereby authorize AltaPointe to provide me with treatment services, and if it is my child or ward, I hereby give consent for treatment:
Services may include the prescription of psychoactive medications and the administration of those medications by approved program staff. Emergency medications may be given to the patient (by mouth or injection) to prevent harm to themselves or others.
Children and adolescent inpatient patients will receive educational services on site as appropriate. Classrooms may consist of students receiving special and/or regular educational services. Due to our emphasis on treatment of emotional and behavioral difficulties patients will not be eligible to receive the same number of credits as they would on a public-school campus.

_____ **Consent for Follow-up contact:** I consent to AltaPointe staff members contacting ____**myself** ____**other contact** by letter, questionnaire, or telephone for establishing my current condition. I understand this information will be held in confidence and will not be disclosed without my written consent. I further understand this consent for follow-up will remain valid for a period of **ONE** year following my discharge from the program. I understand that I may revoke this consent at any time in writing. □ **I do not want to be contacted**.
Name: _____Address: _____ Phone#: _____

_____ **Health Information Exchange (HIE):** AltaPointe participates in a HIE called Care Quality and other designated HIEs. I understand that any physician or hospital that participates in the HIE either directly or indirectly may request for the purpose of my continuity of care the following limited set of records regarding my care: Allergies, Demographics, Labs, Immunizations Medications, and Problem Lists. You may choose to Opt-Out of allowing your health information to be shared through the HIE by requesting an Opt-out form.
All other releases will follow the practices explained in your Notice of Privacy Practices.

_____ **Payment Agreement:** For and in consideration of services rendered by AltaPointe, the patient (responsible person) hereby agrees to and guarantees payment of all AltaPointe charges incurred for the account of the patient from the date of admission until discharge. I understand that if an agency or company is responsible for payment of services, that agency or company will have the right to review the services I receive from AltaPointe. If the Probate Court placed me at AltaPointe, I understand that my insurance along with contract fees will be used to pay for services rendered while I am receiving services at AltaPointe.

I also understand that that I may be charged a fee or co-payment for services and that it is expected, if I am responsible for the payment of these services, to pay for them as they are received. I further understand I should contact AltaPointe if there are any changes to my insurance. A no-show fee may be charged if applicable.

Methods of Payment – Our office accepts the following payment methods: Cash, Personal Check, Credit Cards, and Money Orders.
There will be a $25.00 NSF charge for all returned checks.

_____ **Fee Schedule:** I understand that I am responsible for payment for services rendered by AltaPointe Health, Inc. at its standard rates provided to me on the fee schedule.

_____ **Self-Pay –** I agree to pay AltaPointe in full for services rendered.

_____ **Medicaid:** Patient certifies that the information given in applying for payment under Title XIX (19) of the Social Security Act is correct. Patient authorizes any holder of medical or other information about the patient to release to the respective State Medicaid Agency or its intermediaries or insurance carries any information needed for this or a related medical claim. Patient requests that payment of authorized benefits be made on his/her behalf.

N/A **Medicare:** Patient certifies that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct. Patient authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or insurance carries any information needed for this or a related medical claim. Patient requests that payment of authorized benefits be made on his/her behalf.

_____ **Assignment of Insurance Benefits and Agreement to Pay Any Balance**: Patient (responsible party) irrevocably assigns and transfers to AltaPointe all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering patient, for the payment of treatment and medical care being provided. Patient (responsible party) authorizes payment directly to AltaPointe Health of said medical reimbursement benefits. Patient (responsible party) is responsible for and co-payments, co-insurance, deductibles, and/or other amounts specified by my insurance. In the event the said medical insurance coverage is not sufficient to satisfy the AltaPointe charge in full, patient (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment. I understand that my agreement with my insurance carrier is a private one, and that AltaPointe does not routinely research why my insurance carrier has not paid or why it paid less than anticipated for care.

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AltaPointe Health Statement of Understanding and Consents pg. 2

_____ **No Surprise Billing**: I have been informed of my right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees. The estimate is based on information known at the time the estimate was created and should complications or special circumstances occur, I could be charged more. If I am charged more, I have the right to dispute.

_____ **Integrated Healthcare Pharmacy Services**: As a patient at AltaPointe Health my prescriptions may, but are not required, to be filled at the Integrated Healthcare Pharmacy located at Gordon Smith Drive. AltaPointe Health has an ownership interest in Integrated Healthcare Pharmacy and offers the on-site pharmacy services for the convenience of the patient. It is the patient's decision as to where he/she chooses to fill their prescription.

_____ **Consent for Residents, Interns, and Medical and Nursing Students to Participate in my Treatment**: I am aware that, residents, interns, medical and nursing students, could be present for educational purposes. I understand that in the educational process they may observe or participate in my or my child's treatment and/or review my or my child's medical record.

_____ **Family Involvement**: Family involvement is an integral part of treatment especially when treating children and adolescents. I agree to make every reasonable effort to assist my or my child's therapist in scheduling a convenient time for this family therapy session. I do understand that failure to meet this requirement can result in denials of insurance payment related to non-compliance with treatment.

_____ **Responsibility for Destruction of Property**: The undersigned understands that patients are responsible for any damage to or destruction of AltaPointe property, or property belonging to others which may be located at AltaPointe. The undersigned and/or legal guardian agree to accept liability of and reimburse AltaPointe or other owners of property which the patient may damage or destroy.

_____ **Confidentiality of Information and Group Participation**: I understand that any information which is disclosed to me while I am a patient at this facility is confidential and that this information is protected by Federal law. I understand that this means that I will respect the rights of other participants by not talking with others outside the facility about what is said in treatment groups.

_____ **Patient Rights Statement**: I understand that AltaPointe subscribes to a Patient Rights Statement, which has been made available to me. I have had the opportunity to have the Patient Rights Statement explained to me.

_____ **Grievance Process**: I have been furnished with a copy of the Grievance process and had it explained to me.

_____ **Procedure to Review Records**: I have been furnished with a copy of the Procedure to Review my health record and had it explained to me.

_____ **Notice of Privacy Practices**: I have been furnished a copy of the Notice of Privacy Practices and have had it explained to me. I understand that the information concerning the treatment of _____ will be held in confidence by the AltaPointe staff unless I give specific written consent for the release of information. In case of emergency AltaPointe is authorized to request or release that information which is essential to handle the emergency.

Also, AltaPointe staff will not release any information except as required by law or Court Order under compelling disclosure, or in a situation deemed potentially life-threatening, and in the following instances: Suspected Child Abuse, threats of physical harm to self and/or others, espionage, or sabotage.

The confidentiality of your participation may also be protected by federal and state laws and regulations. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a patient's commission of a crime against AltaPointe property or personnel, or reports under state law of suspected child abuse or neglect (See 42 U.S.C. 290 ee 3 for federal laws 42 CFR Part 2 for federal regulations).
Please refer to the Health Information Exchange section of this document for HIE information.

_____ **Special Equipment**: I understand that special equipment, in the form of cameras, may be utilized at the facility for the safety of the patients.

_____ **Rehabilitation Act:** It is the policy of AltaPointe, in compliance with Section 504 of the Rehabilitation Act of l973, to afford qualified handicapped persons an opportunity to receive benefits or services that are equal to that offered non-handicapped persons. Any person who feels he/she has not received treatment in accordance with this policy may submit a compliant with the Patient Relations Department, AltaPointe Health, 5750-A Southland Drive., Mobile, Al. 36693.

_____ **Consent to Photographs**: I consent to have my photograph taken by the staff at AltaPointe as part of the admission process. I understand that this photograph will be placed in my individual medical record in keeping with this facility's system of patient identification and will be used for identification purposes only when necessary, during the course of my treatment.

_____ **Consent to Search**: I do hereby give my willing and informed consent to AltaPointe to search my personal belongings in my presence. **This consent is given to ensure that neither I nor anyone else in this facility has any prohibited items (dangerous objects, medications, contraband, or any other prohibited items**). I do understand that this search would also be performed in the event of my leaving the facility by the appropriate clinical staff member as AltaPointe deems necessary. I do also understand that this search is to include socks and underwear.

_____ **Responsibility for Personal Articles**: Patient (responsible person) acknowledges and agrees that AltaPointe does not assume responsibility for any personal possessions. Patient and/or legal guardian acknowledges and agrees to accept responsibility for any personal possessions. Patient acknowledges and agrees to accept responsibility for clothing and/or personal effects including dentures, eyeglasses, hearing devices, etc.

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_____ **Consent to Text**: I consent to receiving automated text alerts from AltaPointe on my mobile phone. Text alerts may be about appointments, test results, surveys, healthcare outreach, and more.

N/A **Psychiatric Advance Directives:** ***(All Adult Programs)*** ___ I have a psychiatric advance directive and have provided a copy to AltaPointe. ___ I do not have a psychiatric advance directive and have been provided information by AltaPointe.

N/A **Infection Prevention and Control Training:** I have received training on Infection Prevention and Control and had an opportunity to ask questions.

Children's Outpatient Programs

N/A **Children's Outpatient Program Admission Agreement**: I have been furnished with a copy of the admission agreement. ithas been explained to me

Residential / Hospital Program

_____ **Seclusion & Restraint: The Last Resort**: I understand that AltaPointe's policy is to use Seclusion and Restraint only as a last resort. I have been given a copy of their policy and had the opportunity to ask questions. Physical restraint and/or seclusion may be used only in an emergency to protect the patient or others from imminent risk of harming self or others. This procedure has been explained to me. I understand that this is not used as punishment, but only as an emergency procedure. I understand that an attempt will be made to contact: Name _____ Relationship: _____Phone Number: _____.

N/A **Consent for Participating in and Transport to Off-Ground Activities and therapies**: I give permission for me or my child to participate in off-ground activities such as movie, skating, museums, bowling, plays, etc., as approved by the attending physician. I understand that AltaPointe will provide reasonable supervision and will take reasonable precautions to provide for the safety and well-being of me and/or my child.

N/A **Adult Residential Services and Transitional Age Residential Financial/Medical/Dental Responsibility Agreement:** As a resident of a residential care home, I understand that (1) I am charged up to 75% of my monthly income or up to $900 for room and board. (2) My room, board charges may be changed if my income changes. I am responsible for up to 75% of all my income for room and board for those months for which I am eligible. (3) I will reimburse the program for all personal expenses incurred while a resident at AltaPointe Health to include, but is not limited to, any property damage personally created. (4) I understand that AltaPointe provides no routine medical and dental care. The provision of payment for routine and major medical costs must be made prior to admission through patient resources, acceptable third party, or warranty by the sponsoring agent. I understand that I will be responsible for all my medical and dental care. If my relative/guardian/sponsor accepts responsibility for my medical and dental care, the signature is affixed below.

_____ **Child/Adolescent 24 Hour Care Program Elopement Report Permission**: I hereby give my permission as parent/legal guardian for the staff at AltaPointe to notify local law enforcement (police and/or sheriff's departments) of my child's full identity in the event of his/her unauthorized elopement from AltaPointe and/or the grounds. Identifying information may include name, birthdate, name(s) of parent(s), home address, and any other identifying information deemed potentially helpful in such a report.

_____ **Emergency Medical/Surgical Services**: I authorize and give my consent to AltaPointe staff to seek and obtain emergency medical/surgical treatment or dental treatment services as needed.

N/A **Medical Advance Directives:** ___I have a medical advance directive and have provided a copy to AltaPointe. ___ I do not have a medical advance directive and have been provided information by AltaPointe.

_____ **Consent for Sex education**: State and National Guidelines for child/adolescent treatment facilities require that the patients be offered the chance to participate in sex education classes. AltaPointe will offer these classes on an informational level to those patients who are of age to make their own informed decision or whose parents/guardians wish to have them enrolled. I give consent for my child to participate in informational sex education classes.

_____ **Consent to Attend Church-Related Activities**: I agree or give permission for my child to attend church-related activities while a patient at AltaPointe. **(24-hour care programs)**

_____

Print Patient's Name Patient's Signature Date

_____ _____

Parent/Legal Guardian Signature Date Witness Signature/Credentials Date

_____

Witness Signature/Credentials (**required when signed with a mark**)

If patient signature is not present mark reason:

_____ Patient Unable to Sign _____ Patient refused to Sign (Show multiple attempts)

Date: _____ Date: _____

Date: _____Date: _____

MR#: | | | | | | | EP: | | Date: | | | – | | | – | | | | |
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ALTAPOINTE HEALTH

INFORMED CONSENT FOR PSYCHIATRIC TELEHEALTH SERVICES

Patient Name: _____

Healthcare Practitioner: AltaPointe Health Credentialed Provider

Introduction

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient health information for the purpose of improving patient care. **This consent is valid for twelve months.** The information obtained may be used for diagnosis, therapy, follow-up, referral, and/or consultation, and may include one or both of the following:

- Live two-way audio and video
- Output data from medical devices and sound and video files

The interactive tele-video equipment and telecommunication lines used are HIPAA approved for patient security and privacy.

Expected Benefits

- Improved access to psychiatric care by enabling a patient to have a session with a psychiatrist while remaining at a remote site,
- More efficient medical evaluation and management.

Possible Risks

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment,
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information.

By signing this form, I understand the following:

1. The laws that protect privacy and the confidentiality of psychiatric information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to other entities without my written or verbal consent.
2. I have the right to withhold or withdraw my consent (either written or verbally) to the use of telehealth in the course of my care at any time.
3. I understand that the health care provider is off site at a remote location.
4. I understand that none of the teleconference will be recorded or photographed.
5. I understand that in the event of technical difficulties an employee of the IT department, as well as additional staff, may be present during my session.
6. I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
7. If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:_____
8. The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my **additional** written consent.
9. I will be informed of all people who will be present at all sites during my telemedicine service.
10. I may exclude anyone from any site during my telehealth service.
11. I may see an appropriately trained staff person, or employee, in-person, immediately after the telemedicine service if an urgent need arises. **OR,** I will be told ahead of time that this is not available.
12. I may contact the healthcare provider at phone number _____ for any questions I have related to medical services received through a telemedicine provider/site.

I understand that this consent will expire on _____ (Twelve months from the signature date) **or** at the time of my discharge from this program, whichever comes first.

I have read this document carefully, and my questions have been answered to my satisfaction.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

OR Signature of Parent or Legal Representative: _____ Date: _____

Signature of Witness & Credentials/ Title Obtaining Telemedicine Consent: _____ Date: _____

MR#: EP: Date: M M – D D – Y Y Y Y

ALTAPOINTE HEALTH

INFORMED CONSENT FOR VERBAL / EMAIL EXCHANGE OF INFORMATION

I, _____ hereby consent to the verbal/ email exchange of information between
(Print patient name)

AltaPointe Health and: _____
(Guardian Name, Email Address, and Phone Number which information will be discussed with)

regarding Treatment, Medication, Diagnosis, and Discharge
(Information that will be discussed)

For admission of _____ and for the following purpose:
(Date of admission)

☐ Facilitate Evaluation and Treatment
☐ Participate in treatment
☐ Other
Specify: _____

I understand that this consent will expire on _____ (Two year from the signature date) **or** at the time of my discharge from this program, whichever comes first. I understand that I may revoke this consent at anytime. The revocation may be given *verbally or in writing*, and it will not apply to information that was discussed prior to my revocation of this consent.

I have been informed that copies of my medical record can only be released by my signing an authorization giving my permission to do so.

_____ _____
Patient Signature Date

_____ _____
Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

_____ _____
Witness Signature (if appropriate) Date

MR#: EP: Date: M M – D D – Y Y Y Y

ALTAPOINTE HEALTH

INFORMED CONSENT FOR VERBAL / EMAIL EXCHANGE OF INFORMATION

I, _____ hereby consent to the verbal/ email exchange of information between
(Print patient name)

AltaPointe Health and: _____
(School Name/ Contact Person or Email Address which information will be discussed with)

regarding Treatment, Medication, and School Behavior
(Information that will be discussed)

For admission of _____ and for the following purpose:
(Date of admission)

☐ Facilitate Evaluation and Treatment
☐ Participate in treatment
☐ Other
Specify: _____

I understand that this consent will expire on _____ (Two year from the signature date) **or** at the time of my discharge from this program, whichever comes first. I understand that I may revoke this consent at anytime. The revocation may be given *verbally or in writing*, and it will not apply to information that was discussed prior to my revocation of this consent.

I have been informed that copies of my medical record can only be released by my signing an authorization giving my permission to do so.

_____ _____
Patient Signature Date

_____ _____
Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

_____ _____
Witness Signature (if appropriate) Date

MR#: EP: Date: M M – D D – Y Y Y Y

ALTA POINTE HEALTH
PSYCHOTROPIC MEDICATION CONSENT FORM

Patient Name: _____

I hereby acknowledge that I have received verbal and/or written educational material from my Physician/Nurse regarding the benefits, risks, and alternatives to treatment with: _____.

I have had the opportunity to ask questions, and I fully understand the information presented. I consent to take the medication (s) and realize that I may withdraw my consent at any time, in writing.

Do not sign this consent if you have not received verbal and/or written information and educational material regarding the medication you will be taking or if you have further unanswered questions.

_____ _____
Patient's Signature Date Guardian/Legal Rep. Signature Date

_____ _____
Witness Signature Date Witness Signature (for use only if patient signs with a mark)

****

I hereby acknowledge that I have received verbal and/or written educational material from my Physician/Nurse regarding the benefits, risks, and alternatives to treatment with: _____.

I have had the opportunity to ask questions, and I fully understand the information presented. I consent to take the medication (s) and realize that I may withdraw my consent at any time, in writing.

Do not sign this consent if you have not received verbal and/or written information and educational material regarding the medication you will be taking or if you have further unanswered questions.

_____ _____
Patient's Signature Date Guardian/Legal Rep. Signature Date

_____ _____
Witness Signature Date Witness Signature (for use only if patient signs with a mark)

****

I hereby acknowledge that I have received verbal and/or written educational material from my Physician/Nurse regarding the benefits, risks, and alternatives to treatment with: _____.

I have had the opportunity to ask questions, and I fully understand the information presented. I consent to take the medication (s) and realize that I may withdraw my consent at any time, in writing.

Do not sign this consent if you have not received verbal and/or written information and educational material regarding the medication you will be taking or if you have further unanswered questions.

_____ _____
Patient's Signature Date Guardian/Legal Rep. Signature Date

_____ _____
Witness Signature Date Witness Signature (for use only if patient signs with a mark)

MR#: | | | | | | | EP: | | Date: | | | – | | | – | | | | |
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CONSENT FOR PET THERAPY

I, _____, give consent for
(Guardian/ Legal Representative Name)

_____, to participate in the Pet
(Patient Name)

Therapy program at _____and verify that he/she does not

have any pet allergies.

_____ _____
Patient Signature Date

_____ _____
Guardian/ Legal Representative Signature Date

_____ _____
Witness Signature Date

10/21/13 Revised 11/30/2022
BC 92077


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ALTAPOINTE HEALTH

ARBITRATION AGREEMENT

Patient Name: _____

Authorized Representative (Parent/Guardian): _____

THIS AGREEMENT IS NOT A CONDITION OF ADMISSION TO OR CONTINUED STAY AT BAYPOINTE HOSPITAL

I. Summary

This Agreement requires the resolution of disputes through alternative dispute resolution ("ADR"). ADR is an alternative to bringing your disputes in court to be decided by a judge or jury. Arbitration is one form of ADR, and it is a procedure in which the parties submit a dispute to one or more mutually selected, impartial persons—known as arbitrators—for a final and binding decision. Arbitration is more informal and can be faster and less expensive than a lawsuit in court. The arbitrator's decision is subject to very limited review by courts.

Arbitrators can award the same damages and other individualized relief that a court can award. You may be represented by a lawyer in arbitration if you wish. **With the execution of this Agreement, the Parties to this Agreement are agreeing that all disputes between the Parties to this Agreement will be resolved by binding arbitration. This Agreement waives the right to trial by jury.** Any arbitration under this Agreement will take place on an individual basis; class arbitrations and class actions are not permitted.

II. The Parties to This Agreement

This Arbitration Agreement (hereinafter referred to as the "Agreement") is entered into by AltaPointe Health Services, Inc. ("AltaPointe") and _____, on behalf of and as the parent/guardian (the "Authorized Representative") of _____, who is a patient at AltaPointe's BayPointe Hospital facility (the "Patient"). The term "AltaPointe" as used in this Agreement shall refer to AltaPointe Health Services, Inc., its employees, agents, officers, directors, medical directors, affiliates, providers (including but not limited to BayPointe Hospital) and any parent or subsidiary of AltaPointe. The term "Patient" as used in this Agreement shall refer to the Patient, all persons whose claim is or may be derived through or on behalf of the Patient or his/her estate, including any Patient representative, next of kin, guardian, executor, administrator, legal representative, or heir of the Patient, and any person who has executed this Agreement on the Patient's behalf. As used in this Agreement, the term "Party" shall refer to AltaPointe or the Patient, and the term "Parties" shall refer to both of them. It is the intent of the Parties and the Authorized Representative that this Agreement shall inure to the benefit of, bind, and survive them, their successors and assigns.

III. Voluntary Agreement to Participate in Arbitration

The Parties agree that any disputes covered by this Agreement ("Covered Disputes") that may arise between them shall be resolved through binding arbitration. The Parties to this Agreement acknowledge and agree that upon execution by the Authorized Representative of the Patient, this Agreement becomes part of the Admission Agreement, and that the Admission Agreement evidences a transaction in interstate commerce governed by the Federal Arbitration Act. The relief available to the Parties under this Agreement shall not exceed that which otherwise would be

available to them in a court action based on the same facts and legal theories under the applicable federal, state or local law.

THE PARTIES UNDERSTAND, ACKNOWLEDGE, AND AGREE THAT THEY ARE SELECTING A METHOD OF RESOLVING DISPUTES WITHOUT RESORTING TO LAWSUITS OR THE COURTS, AND THAT BY ENTERING INTO THIS AGREEMENT, THEY ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE THEIR DISPUTES DECIDED IN A COURT OF LAW BY A JUDGE OR JURY, THE OPPORTUNITY TO PRESENT THEIR CLAIMS AS A CLASS ACTION AND/OR TO APPEAL ANY DECISION OR AWARD OF DAMAGES RESULTING FROM THE ARBITRATION PROCESS EXCEPT AS PROVIDED HEREIN.

Except as specifically provided in this Agreement, the Parties' resort to a court of law shall be limited to an action to enforce a binding arbitration decision entered in accordance with this Agreement or to vacate such a decision based on the grounds set forth in the Federal Arbitration Act, 9 U.S.C. sections 1 - 16, or the law of the state where AltaPointe is located. The Parties agree that the speed, efficiency, and cost-effectiveness of the arbitration process, together with their mutual undertaking to engage in that process, constitute good and sufficient consideration for the acceptance and enforcement of this Agreement.

IV. Covered Disputes

This Agreement applies to any and all disputes arising out of or in any way relating to this Agreement or to the Patient's stay or care provided at AltaPointe or the Admission Agreement between the Parties that would constitute a legally cognizable cause of action in a court of law sitting in the state where AltaPointe is located. The Parties agree that AltaPointe is providing healthcare and medical care services to the Patient, and that Covered Disputes include but are not limited to all claims in law or equity arising from one Party's failure to satisfy a financial obligation to the other Party; a violation of a right claimed to exist under federal, state, or local law or contractual agreement between the Parties; tort; breach of contract; consumer protection; fraud; misrepresentation; negligence, gross negligence; malpractice; and any alleged departure from any applicable federal, state, or local medical, health care, consumer, or safety standards. All claims for monetary damages against AltaPointe must be arbitrated including, without limitation, claims for personal injury, wrongful death, mental anguish, emotional distress, or loss of consortium.

Nothing in this Agreement shall limit the right of the Patient or anyone else to communicate with federal, state, or local officials, including but not limited to, federal and state surveyors, or other federal or state health department employees. This Agreement also shall not prevent any Party from seeking interim equitable relief from a court of competent jurisdiction to prevent irreparable harm or to preserve the positions of the Parties pending arbitration, or to seek appointment of an arbitrator. In addition, the Parties are not precluded by this Agreement from seeking remedies in small claims court for disputes or claims within its jurisdiction.

All claims based in whole or in part on the same incident, transaction, or related course of care or services provided by AltaPointe to the Patient shall be addressed in a single arbitration process, which shall adjudicate solely the claims of the Parties named in this Agreement, and no others. A claim by the Party initiating the arbitration process shall be waived and forever barred if it arose and was reasonably discoverable prior to the date upon which notice of arbitration is given to AltaPointe or the Patient and such claim is not presented in the arbitration proceeding. A claim that is not brought within the statute of limitations period that would apply to the same claim in a court of law sitting in the state where AltaPointe is located also shall be waived and forever barred. The

arbitrator shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability or formation of this Agreement is void or voidable.

V. Administration and Process

A. To resolve a dispute, either of the Parties (or the Authorized Representative) may serve the other party with a Demand for Arbitration (the "Demand"). A Demand can be made by sending a letter to a Party's representative. If to AltaPointe, Patient should send the Demand in writing to the Vice President and Chief of Staff, whose address is 5750-A Southland Drive, Mobile, Alabama 36693.

B. After a Demand has been made, the dispute shall proceed to binding arbitration.

C. Any arbitration that is conducted shall be administered by an independent impartial entity or individual who is regularly engaged in providing arbitration services and who is not a regular employee or agent of either of the Parties or their counsel.

D. To the extent the Parties can agree upon a single Arbitrator, that single Arbitrator shall hear and decide the controversy, and the decision shall be binding on all Parties, and may be enforced by a court of competent jurisdiction. To the extent the Parties cannot agree upon a single Arbitrator, each side shall choose a single Arbitrator (a total of two), who will in turn choose a third Arbitrator to serve on the panel. In the latter case, all three Arbitrators shall participate in the hearing and shall render a joint decision, and the decision shall be binding on all Parties, and may be enforced by a court of competent jurisdiction. In such event, at least two of the three Arbitrators must agree in order to reach a decision.

E. The Parties agree that Arbitration pursuant to this Agreement shall be held at a location that is convenient to both parties, or in the absence of an agreement, at a neutral location in Mobile County, Alabama, and shall be conducted in accordance with the provisions of the Federal Arbitration Act.

F. The Parties shall be entitled to conduct discovery in arbitration subject to and consistent with the laws of the State of Alabama, including but not limited to the Alabama Medical Liability Act ("AMLA"). The Arbitrator(s) shall resolve all issues regarding the scope of discovery and may in accordance with applicable law, upon the request of the Party or upon the Arbitrator's or Arbitrators' own motion, issue subpoenas for the appearance and testimony of witnesses in discovery and at the arbitration and for the production of documents. The Arbitrator(s) shall have subpoena power consistent with the Federal Arbitration Act. All evidence shall be presented to the Arbitrator(s) in accordance with the Alabama Rules of Evidence and the AMLA.

G. The Arbitrator(s) may grant any remedy or relief within the scope of the Agreement of the parties that the Arbitrator(s) deems just and equitable and which is consistent with applicable law. The decision of the Arbitrator(s) shall be made and delivered in accordance with the Federal Arbitration Act. The decision shall be delivered to the parties and their counsel no later than thirty (30) days following the conclusion of the hearing, unless both Parties consent to an extension. The arbitration decision shall set forth the Arbitrator's or Arbitrators' findings of fact and conclusions of law in detail, including whether any liability has been found. The decision shall be binding on all Parties, and may be enforced by a court of competent jurisdiction.

H. Except as required for submission to a court having jurisdiction for purposes of enforcement, no Party or Arbitrator may disclose the existence, content, or results of any arbitration hereunder without the prior written consent of all of the Parties or unless required by law.

I. The Parties agree that damages, if any, awarded in an arbitration conducted pursuant to this Arbitration Agreement shall be determined in accordance with the provisions of the State or Federal law applicable to a comparable civil action, including any prerequisites to, credit against, or limitations on such damages.

VI. Costs and Fees

The Parties agree that all administrative fees and costs, including the fees of the Arbitrator(s), shall be split between the Parties with AltaPointe paying fifty percent (50%) and the Patient paying fifty percent (50%). The Parties further agree that each party shall be responsible for their own attorneys' fees. If a party prevails on a statutory claim which provides for the prevailing party to receive payment for its attorneys' fees, or if there is a written agreement between the parties providing for the prevailing party to receive payment for its attorneys' fees, the arbitrator may award reasonable fees to the prevailing party in accordance with the standards established under such statute or agreement.

VII. Governing Law

Except as otherwise provided herein, this Agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. §§ I et seq. The substantive law of the state law of Alabama shall be applicable to the Covered Disputes.

VIII. Severability

If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable in whole or in part the remainder of this Agreement including all valid and enforceable parts of the provision in question (specifically including but not limited to the Admission Agreement, to the extent this Agreement becomes a part of the Admission Agreement), shall remain valid, enforceable, and binding on the Parties.

IX. Proof of Agreement

The Parties agree and stipulate that the original of this Agreement, including the signature page, may be scanned and stored in a computer database or similar device, and that any print-out or other output readable by sight, the reproduction of which is shown accurately to reproduce the original of this document, may be used for any purpose just as if it were the original, including proof of the content of the original writing. This agreement shall be binding upon AltaPointe when signed by or on behalf of the Patient, regardless of whether this Agreement has been signed by an AltaPointe representative.

X. Binding Nature of Arbitration and Judicial Review

The decision of the arbitrator(s) shall be final and binding on AltaPointe and Patient.

Either party may bring an action in a court of competent jurisdiction to require arbitration under this Agreement and to enforce an arbitration award. A party opposing enforcement of an

award must bring a separate action in any court of competent jurisdiction to set aside the award. Review of the award by a court will take place under the standards set forth in the Federal Arbitration Act, 9 U.S.C. § 1 et seq.

XI. Patient's Understanding and Rescission

By signing below, the Authorized Representative of the Patient acknowledges that: (1) this Agreement has been explained to the Authorized Representative by a representative of AltaPointe in a form and manner that the Authorized Representative understands including in a language the Authorized Representative understands; and (2) the Authorized Representative understands this Agreement.

The Authorized Representative also understands that he/she has the right to seek legal counsel concerning this Agreement. The Authorized Representative also understands and acknowledges that his/her signature to this Agreement is not a condition of admission for the Patient to, or residence in, AltaPointe, and that this Agreement shall remain in effect for all care and services rendered to the Patient at or by AltaPointe regardless of whether the Patient is subsequently discharged and readmitted to AltaPointe without renewing, ratifying, or acknowledging this Agreement. This Agreement survives the termination of any Admission Agreement or any other contract between the Parties.

THIS AGREEMENT GOVERNS IMPORTANT LEGAL RIGHTS. PLEASE READ IT CAREFULLY AND IN ITS ENTIRETY BEFORE SIGNING.

This Agreement should be signed by the Authorized Representative of the Patient. The Authorized Representative acknowledges that he or she is the parent/guardian of the Patient and has the custodial rights sufficient to execute this Agreement on behalf of the Patient and has been expressly and fully authorized by the Patient to execute this Arbitration Agreement.

I hereby acknowledge that I have read and/or been given the opportunity to read this Arbitration Agreement and consent to the terms herein.

Authorized Representative Signature	Date
Authorized Representative Printed Name	Representative's Legal Designation

By signing this Agreement, I personally represent that I have full power and authority to sign on behalf of and bind AltaPointe to the terms of this Agreement.

AltaPointe Health Services, Inc. Representative Signature	Date
AltaPointe Health Services, Inc. Representative Printed Name	

NOTICE OF HEALTH INFORMATION 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 IT CAREFULLY.

We have a legal duty to safeguard your (PHI) Protected Health Information. This PHI includes information that can be used to identify you that we have created or reviewed about your past, present or future health conditions. It contains what healthcare we have provided to you, or the payment history on healthcare related accounts. We must provide you with notice about our privacy practices and explain how, when and why we use and disclose your PHI.

We will not use or disclose your health information without your authorization, except as described in this notice or otherwise required by law. We are legally required to follow the privacy practices that are described in this notice.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS:

The confidentiality of alcohol and drug abuse records maintained by this organization is protected by federal law and regulations. Generally, the program may not communicate to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser unless one of the following conditions is met:

* you consent to it in writing
* the disclosure is allowed by a court order
* the disclosure is made to medical personnel in a medical emergency or to qualified personnel for program evaluation

Violations of federal laws and regulations by a program are a crime. Suspected violations may be reported to the appropriate authorities in accordance with federal regulations.

Federal laws and regulations do not protect any information about a crime committed by you either at the program or against any person(s) who works for the program or about any threat to commit such a crime.

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.

YOUR HEALTH INFORMATION RIGHTS:

Although your medical record is the physical property of Accordia Health / AltaPointe Health, the information belongs to you. You have the right to:

* request in writing a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
* request in writing to obtain a paper copy of your health record as provided for in 45 CFR 164.524
* request in writing to amend your health record as provided in 45 CFR 164.526
* obtain a paper copy of the notice of information practices upon request
* request in writing to obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
* request in writing communication of your health information by alternative (other) means or at other locations
* revoke in writing your authorization to use and disclose health information except to the extent that action has already been taken
* obtain notice following any breach of your unsecured protected health information as provided in 45 CFR 164.520(b)(1)(v)(A)

OUR RESPONSIBILITIES:

Accordia Health / AltaPointe Health are required to:

* maintain the privacy of your health information
* provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
* abide by the terms of this notice
* notify you if we are unable to agree to a requested restriction
* accommodate reasonable requests you may have to communicate health information by other means or at other locations
* train our personnel concerning privacy and confidentiality; implement a sanction policy to discipline those who breach privacy or confidentiality of our policy

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our Information practices change; the revised notice will be available through your clinician and in the lobby of the facility.

We will not use or disclose your health information without your authorization, except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the Patient Relations Specialist at 251-450-4303.
If you believe your privacy rights have been violated, you can file a complaint with the Patient Relations Specialist at Accordia Health / AltaPointe Health or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Your written statement to Accordia Health / AltaPointe Health and/or the Office of Civil Rights must include your name; address; telephone number; your signature; how, why, and when you believe you were discriminated against; name and address of institution or agency you believe discriminated against you; and any other relevant information.

You may submit in writing a request for review of any discrepancy or complaint under HIPAA to any of the following:

Director
Office of Civil Rights
U.S. Department of Health & Human Service
61 Forsyth St., SW – Suite 31370
Atlanta, GA 30323
(404) 562-7858 or 562-7884

Patient Relations Specialist
Accordia Health / AltaPointe Health
5750-B Southland Drive
Mobile, AL 36693
(251) 450-4303

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:

We will use your health information for treatment (fox example):
Information obtained by a, doctor, nurse or other mental health professional will be recorded in your record and used to determine the course of treatment that will work best for you. Any service provided to you will be documented in the record.

We will use your health information for payment (for example):
A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis. You may request restrictions on such uses only if the request relates to services paid of out-of-pocket and the request is for nondisclosure to a health plan related solely to such services as provided in 45 CFR164.520(v)(1)(iv)(a) and 164.522(a)(1)(vi)

We will use your health information for regular health operations (for example):
Members of the medical staff, the risk or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.

Business Associates:
We provide some services through contracts with business associates. (Example: certain diagnostic tests).

Directory:
We do not have a directory that provides any information concerning your treatment here.

Notification:
We will not disclose any information to anyone about you without your written consent/authorization. Examples of uses or disclosures requiring your authorization includes most disclosures of psychotherapy notes as provided in 45 CFR 164.520(b)(1)(ii)(E)

Comm*unication with Family:*
Only with your written authorization/consent will we disclose to a family member, another relative, a close friend, or any other person that you identify; health information relevant to that person's involvement in your care or payment related to your care.

Research:
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Funeral Directors:
We may disclose health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Marketing/continuity of care:
We may contact you to provide appointment reminders or information about treatment alternatives that may be of interest to you.

Fund raising:
We will not contact you concerning any fund raising activities.

Food and Drug Administration (FDA):
We may disclose to the FDA health information relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or postmarking surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation:
We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health:
We may disclose your health information as required by law.

Correctional institution:
If you are an inmate of a correctional institution, we may disclose to the institution health information necessary for your health and the health and safety of other individuals.

Law Enforcement:
We may disclose your health information for law enforcement purposes as required by law or in response to a court order.

Health Oversight Agencies & Public Health Authorities:
By Federal law provisions your health information may be released provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (MEDICAL RECORDS) THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL HAVE THE REVISED NOTICE AVAILABLE IN THE LOBBY OF THE FACILITY.

Patient Rights

As a patient of Accordia Health / AltaPointe Health, you have the following rights:

- To be treated with respect, consideration, dignity and to receive high quality healthcare.
- To not be discriminated against in the delivery of healthcare services.
- To be assured of confidential treatment and to authorize the release of identifiable healthcare and other personal information.
- To review and receive copies of your medical records and/or request that your records be amended.
- To choose your healthcare provider.
- To be informed of your medical condition, treatment plan, and expected outcome.
- To receive accurate, easily understood information and to request assistance or be represented by parents, guardians, family members, or others in making informed healthcare decisions.
- To refuse treatment and refuse to participate in research.
- To be informed of the names, functions, and credentials of all persons providing service to you and to receive the names and telephone numbers of management.
- To be informed of available services, hours of service, and after hour coverage.
- To have a fair and efficient process for voicing grievances.

Patient Responsibilities

As a patient of Accordia Health / AltaPointe Health, you have the following responsibilities:

- To give truthful and accurate information about your health and past medical treatment.
- To ensure that you fully understand and follow the treatment plan prescribed by your healthcare provider.
- To inform your healthcare provider of any changes in your condition or of any adverse reactions to the treatment plan.
- To keep appointments and inform the center in advance when you are unable to keep an appointment.
- To pay for services rendered in accordance with the fee policy and to provide truthful and accurate financial and/or insurance information to allow for appropriate billing.
- To become informed of and to follow health center rules and regulations concerning patient care and conduct.
- To participate in the management of my care and related activities.

Procedure for Review of Records

Any patient or legal representative of a patient may request an opportunity to review his/her records to obtain information from his/her records at AltaPointe/ Accordia Health. Such a request must be submitted in writing on a facility provided *Release of Authorization to Disclose Protected Health Information* form.

Upon receipt of this request, the Health Information Department shall forward the patient's request and medical record to the clinician for determination if release of information would be detrimental to the patient.

If after review, the clinician determines the information may be released, the requested information will be copied and released to the patient.

The copying fee for such requested records is:

On disc: $6.50 disk fee
On paper: $5.00 labor fee, $1.00 per page for the first 25 pages, $0.50 per page thereafter
$15.00 Certification fee if requested

Requests for Release of Health Information not completed and witnessed at one of our facilities require a notarized validation of identity of the requestor or Two witness signatures with copy of identification.

Appeal Process

Step 1: You may report any complaint/grievance to any employee of AltaPointe/ Accordia Health. All complaints received will be reported to the Patient Relations Specialist. You will receive a response with possible solutions to your complaint within 10 working days from the Patient Relations Specialist.
Step 2: If you are not satisfied with the solution, you may request that your complaint, be reviewed by the Patient Relations Committee. You will receive a response with a possible solution from the Patient Relations Committee within 10 working days.
Step 3: If you are not satisfied with the solution offered by the Patient Relations Committee you may request that your complaint, be reviewed by the CEO of AltaPointe/ Accordia Health. You will receive a response from the CEO within 30 days.

At any time, you may contact the following agencies regarding your complaint/grievance:

Alabama Department of Mental Health -Advocacy Services
1-800-367-0955

Alabama Disabilities Advocacy Program
1-800-826-1675

Patient Relations Department
(251) 450-4303

Department of Human Resources
Mobile County (251) 450-7000
General Information (334) 242-1310
Adult Protective Services (800) 458-7214/ Child Protective Services (334) 242-9500

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about ALTAPOINTE/ ACCORDIA by either calling 1-800-994-6610 or e-mailing complaint@jointcommission.org.

COMPLAINT OR GRIEVANCE PROCESS

You may report any complaint/grievance to any employee of AltaPointe/ Accordia Health. All complaints received will be reported to the Patient Relations Department.

- You will receive a response with possible solutions to your complaint within 10 working days from the Patient Relations Specialist.
- If you are not satisfied with the solution, you may request that your complaint be reviewed by the Patient Relations Department.
- You will receive a response with a possible solution from the Patient Relations Department within 10 working days.
- If you are not satisfied with the solution offered by the Patient Relations Department, you may request that your complaint be reviewed by the Chief Executive Officer of AltaPointe Health.
- You will receive a response from the Chief Executive Officer within 30 days.

At any time, you may contact the following agencies regarding your complaint/grievance.

Alabama Department of Mental Health-Advocacy Services
(800) 367-0955

Department of Human Resources
Mobile County (251) 450-7000
General Information (334) 242-1310
Adult Protective Services (800) 458-7214/ Child Protective Services (334) 242-9500

Alabama Disabilities Advocacy Program
(800) 826-1675

Patient Relations Department
(251) 450-4303

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about AltaPointe/ Accordia Health by either calling (800) 994-6610 or emailing complaint@jointcommission.org

You may also call:

Elder Care at Public Health in Montgomery/Division of Health Care Facilities to report a complaint and/or ask questions about your Advance Directive at (800) 356-9596, Monday-Friday 8am-5pm.
If you call after 5 PM or on weekends you can leave a message.

WHAT TO DO IF YOU HAVE A PROBLEM

1. If you don't like something that happens to you here, tell a grown up right away. Your parents can do this for you too.

We have someone called a Patient Relations Specialist who will talk to you and maybe your parents. She/he will try to find a way to fix the problem. She/he will tell you about her/his ideas in about 10 days.

2. If you don't like what she/he says you can ask the Patient Relations Department for help. They will try to come up with other ideas. They will let you know in about 10 days.

3. If you don't like what they say you can ask our Executive Director for help. He will let you know what he thinks in about 30 days.

You can always call someone at these numbers too:

Alabama Department of Mental Health –Advocacy Services
(800) 367-0955

Alabama Disabilities Advocacy Program
(800) 826-1675

Patient Relations Department
(251) 450-4303

Department of Human Resources
Mobile County (251) 450-7000
General Information (334) 242-1310
Child Protective Services (334) 242-9500

You may contact the Joint Commission's Office of Quality Monitoring to report any concerns or register complaints about AltaPointe/ Accordia Health by either calling 1-800-994-6610 or e-mailing complaint@jointcommission.org.