AKEELA

BEHAVIORAL HEALTH TREATMENT REGISTRATION FORMS

Please Select ALL Akeela Service(s) of Interest:

- ☐ Assessment Center
- ☐ Outpatient – Mental Health
- ☐ Residential – Akeela House
- ☐ Psychiatric Evaluation
- ☐ ADIS
- ☐ Outpatient – Substance Use
- ☐ Residential – Stepping Stones
- ☐ Medication Management

FIRST NAME			
MIDDLE NAME			
LAST NAME			
MAIDEN NAME			
DATE OF BIRTH		**AGE**	

CONTACT INFORMATION	
MAILING ADDRESS	
CITY	
STATE & ZIP CODE	
PRIMARY PHONE NUMBER	**( )**
	We can leave a message on primary phone? ☐ YES ☐ NO
SECONDARY PHONE NUMBER	**( )**
	We can leave a message on secondary phone? ☐ YES ☐ NO
EMAIL ADDRESS	
	It is OK to receive email at the address above? ☐ YES ☐ NO
SOCIAL SECURITY NUMBER	

DEMOGRAPHICS

GENDER

- ☐ Female
- ☐ Male
- ☐ Transgender Female
- ☐ Transgender Male
- ☐ Non-binary or Non-confirming
- ☐ Prefer not to respond

RACE & ETHNICITY

- ☐ Alaskan Native or American Indian (select below)
  - ○ Aleut ○ Athabascan ○ Haida ○ Inupiat
  - ○ Tlingit ○ Tsimshian ○ Yupik
  - ○ Other Tribal Affiliation:
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or Northern African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

(select all that apply)

MARITAL STATUS

- ☐ Cohabitating
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

PREFERRED LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ ASL
- ☐ Other, list:

Interpreter Needed: ☐ YES ☐ NO

AKEELA

PAYER INFORMATION	
PRIMARY PAYER/INSURANCE	**SECONDARY PAYER/INSURANCE**
☐ AK Medicaid ☐ None/Self Pay ☐ Sliding Scale/Income Based ☐ Other - If other, specify	☐ I Have a Secondary Payer/Insurance Name of 2nd Insurance Provider: ☐ No Secondary Payer/Health Insurance

TREATMENT NEEDS
In your own words, please tell us about why you are interested in behavioral health services with Akeela.

SUD AT-RISK IDENTIFIERS	
If female, are you pregnant? (select one)	☐ YES Your Due Date: ☐ NO ☐ Does not Apply
Have you ever injected drugs? (select one)	☐ YES Date of Last Use: ☐ NO
Do you use tobacco products? (select one)	☐ YES If YES, select type ☐ NO ☐ Cigarettes ☐ Cigars ☐ Vape ☐ Pipe ☐ Smokeless
Are you participating in Opioid Replacement Therapy? (select one)	☐ YES Agency/Provider Name: ☐ NO

REFERRAL SOURCE		
Please select who referred you to Akeela for behavioral health services.		
☐ ASAP	☐ Office of Children Services	☐ Alaska Psychiatric Institute (API)
☐ Department of Corrections, Court, or Probation	☐ Other Outpatient Provider	☐ Medical Provider
	☐ Other Social Service Agency	☐ Therapeutic Court
☐ Detox Provider	☐ Other Residential Program	☐ Self
☐ Emergency Department	☐ Private Attorney	☐ Other (Please List):
☐ Friends or Family		

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	**DATE**

AKEELA

FINANCIAL CONSENT

State grants, contracts and client fees fund Akeela treatment programs.

Clients will be charged a fee according to their ability to pay, however, no one will be denied services because of an inability to pay. This fee will be based on your annual gross family income and the number of people dependent upon that income. **All services are rendered without exclusion or discrimination on the grounds of race, color, creed, national origin, or disability.**

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND PAYMENT OF MEDICAL BENEFITS TO Akeela, Inc. Akeela, Inc. will restrict disclosure to reasonably necessary information. This means Akeela, Inc. will **only** communicate limited information to insurance companies when it is reimbursed (pursuant to 42, CFR part 2).

Fees must be paid at the time of the appointment unless other arrangements have been made. Missed appointments may be billed at a flat rate of $30.00 unless cancelled at least 24 hours in advance.

This is to certify that the above information is true and accurate to the best of my knowledge, and that I will be respectful for all financial obligations according to my set fee, which was established in my presence.

CLIENT SIGNATURE	**DATE**
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	**DATE**

AKEELA STAFF SIGNATURE	**DATE**

AKEELA

REFUND POLICY

- Akeela does not provide refunds for any monies paid. **NO EXCEPTIONS.**
- Akeela does not perform assessments on individuals under the influence of drugs and/or alcohol. If you arrive and are under the influence, your appointment may be re-scheduled but there will be no refund tendered.
- This includes pre-paid assessments. It is **your** responsibility to follow through with appointments.
- There is a $30.00 missed appointment fee if the appointment is cancelled or re-scheduled within 24 hours or if you do not show or call in for your appointment. This fee will be payable when you arrive for your assessment.
- If you have any questions or concerns, please contact Shannon Greig, Chief Financial Officer, (CFO) at 907-565-1200 ex 7019.

My signature below signifies that I have read and understand Akeela's Refund Policy.

CLIENT SIGNATURE	**DATE**
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	**DATE**

AKEELA STAFF SIGNATURE	**DATE**

AKEELA

TREATMENT PROGRAMS FINANCIAL INFORMATION

CLIENT INFORMATION		
LAST NAME	**FIRST NAME**	**MIDDLE NAME**
EMPLOYER/SCHOOL	**OCCUPATION**	

A COPY OF YOUR PRIMARY & SECONDARY INSURANCE IS REQUIRED (INCLUDING MEDICAID) (COPY FRONT AND BACK OF CARD)

PERSON RESPONSIBLE FOR THE ACCOUNT		
SUBSCRIBER'S LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**
DATE OF BIRTH	**SOCIAL SECURITY#**	
MAILING ADDRESS	**CITY**	
ZIP CODE	**PHONE NUMBER**	

PRIMARY HEALTH INSURANCE INFORMATION	
PRIMARY INSURANCE COMPANY	
MEMBER ID#	**GROUP ID#**

SECONDARY HEALTH INSURANCE INFORMATION		
IS CLIENT COVERED BY ADDITIONAL INSURANCE ☐ **YES** ☐ **NO**		
SUBSCRIBER'S LAST NAME (Responsible Party)	**FIRST NAME**	**MIDDLE INITIAL**
DATE OF BIRTH	**SOCIAL SECURITY #**	
MAILING ADDRESS	**CITY**	
ZIP CODE	**PHONE NUMBER**	
SECONDARY INSURANCE COMPANY		
MEMBER ID#	**GROUP ID#**	

I authorize the individual below to contact Akeela on my behalf regarding financial payments only. Copy of signed ROI must be on file.

NAME	RELATIONSHIP	PHONE NUMBER

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	**DATE**

TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS AUTHORIZATION

CLIENT INFORMATION							
LAST NAME		**FIRST NAME**		**MI**		**DOB**	

PURPOSE OF AUTHORIZATION

I authorize Akeela, Inc. and its affiliated programs to use and disclose my protected health information (PHI), including information related to substance use disorder treatment, mental health, HIV/AIDS status, and other sensitive health information, for the purposes of treatment, payment, and healthcare operations as defined under federal regulations (42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164). This includes, but is not limited to:

- Coordination of care and referrals between treating providers
- Insurance billing and claims management
- Quality assurance, compliance reviews, audits, and accreditation
- Case management and program evaluation
- Appointment scheduling and administrative operations

AUTHORIZATION DETAILS

This authorization permits Akeela, Inc. to disclose necessary information to health plans, billing companies, treatment providers, and authorized staff involved in delivering or coordinating my care. This includes services provided from **Admission** to **Discharge**, as well as related administrative functions.

ACKNOWLEDGEMENT

I understand that this authorization is voluntary and that I may choose not to sign it. My treatment, enrollment, eligibility for benefits, or payment for services will not be affected by my decision to authorize or withhold consent, except where permitted or required by law. I understand that I may revoke this authorization at any time by submitting a written request to Akeela, Inc. Revocation will not apply to any disclosures or actions already taken based on this authorization prior to its revocation. I understand that my health information, including records related to mental health and substance use disorder (SUD) treatment, is protected under 42 CFR Part 2 and HIPAA. These laws limit how my information can be used and disclosed. I understand that any information disclosed under this authorization may not be re-disclosed by the recipient without my written consent, unless specifically permitted under 42 CFR Part 2. A general authorization is not sufficient for this purpose. I understand that my information may be used or disclosed only for the purposes of treatment, payment, and healthcare operations, and that use of this information for any other purpose, including criminal investigation or prosecution, is prohibited unless specifically allowed by federal law. This authorization will remain in effect until 12 months after my discharge from services with Akeela, Inc., unless I revoke it in writing sooner.

RIGHT TO REVOKE

I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to any information that has already been disclosed or actions already taken in reliance on this authorization prior to the date the revocation is received. To revoke this authorization, I must submit my request in writing to Akeela by mail at 360 W. Benson Blvd. Suite 300, Attention: Privacy Officer, Anchorage, AK 99503, in person, or via secure portal message.

CONSENT SELECTION (Select one of the following)

☐ I **CONSENT** to the use and disclosure of my protected health information for treatment, payment, and healthcare operations.

☐ **I DO NOT CONSENT** to the use and disclosure of my protected health information for these purposes.

CLIENT SIGNATURE	**DATE**
CLIENT GUARDIAN/REPRESENTATIVE (if applicable)	**AUTHORITY OF REPRESENTATIVE**
AKEELA STAFF SIGNATURE	**DATE**

RECIPIENT INFORMATION - REDISCLOSURE NOTICE: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2. (ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or (iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).

AKEELA

AKEELA FEE SCHEDULE

Behavioral Health Services Fee Schedule – Effective on 07/01/2025

CLIENT'S FULL NAME	CLIENT DATE OF BIRTH

All clients are responsible for full payment of services provided to them by Akeela, Inc at the time service is provided.

Screening/Assessments (Sliding Fee Scale does not apply)						
Assessment Screening Tool	$	145.00	per assessment	No SFS		**Included in Assessment price below**
Integrated MH / SU Intake Assessment	$	750.00	* per session	No SFS	*	$150 Discount when paid in full at time of service
Alcohol / Drug Assessment	$	530.00	* per session	No SFS	*	$150 Discount when paid in full at time of service
Mental Health Intake Assessment	$	670.00	* per session	No SFS	*	$150 Discount when paid in full at time of service
Psychiatric Assessments - By MD, PA ,ANP only	$	695.00	per session	No SFS		
Clinic Services - Mental Health						
Individual / Family Psychotherapy	$	170.00	per hour			
Group Psychotherapy	$	80.00	per hour			
Multi-Family Psychotherapy	$	120.00	per hour			
Crisis Intervention / Stabilization	$	160.00	per hour			
Pharmacologic Management	$	180.00	per occurrence	No SFS		
Rehab Services - Substance Use						
Individual / Family Services	$	145.00	per hour			
Group Services	$	80.00	per hour			
Treatment Plan Development / Review	$	155.00	per occurrence			
Residential Services (Sliding Fee Scale does not apply)						
Akeela House	$	18.25	per Bed/day	Submission of Quest Card Required		
Stepping Stones	$	13.34	per Bed/day			
Other Services (Sliding Fee Scale does not apply)						
No Show Fee	$	30.00	per occurrence	No SFS		
ADIS Class	$	150.00	per 3 day class	No SFS		

Sliding Fee Scale discounts available to self-pay clients that qualify.
If you would like to apply for a SFS, please ask for assistance.

Proof of income, along with completed and signed Sliding Fee Scale paperwork, is required to receive a Sliding Fee Scale discount. All clients will be billed at a 100% fee for services provided to them until financial documentation is reviewed and approved by billing department staff. Sliding Fee Scale discounts are available to self-pay clients only and will take effect as of the first day of the month in which acceptable proof of income is received.

As a courtesy, Akeela will bill and collect from all other sources of insurance first before billing the client for the balance. Proof of valid insurance required prior to billing of insurance. This includes all private insurance as well as Denali Care/Denali Kid Care (Medicaid). Akeela is not in network with any private insurance companies. Insurance coverage and/or payment depends on each individual policy and is not guaranteed.

Clients must bring in their insurance card if they wish to have Akeela bill their insurance. Denali Care/Denali Kid Care (Medicaid) is insurance. Insurance will only be billed providing all required paperwork is completed and signed. Insurance billing will begin as of the first day of the month in which proof of valid insurance is received.

I have received a copy of the above Fee Schedule and agree to the above rates and terms.

CLIENT, PARENT, OR GUARDIAN SIGNATURE	PARENT OR GUARDIAN NAME	DATE

I hereby assign my benefits payable for services provided to me, by Akeela, Inc., be remitted to Akeela, Inc.

CLIENT, PARENT, OR GUARDIAN SIGNATURE	PARENT OR GUARDIAN NAME	DATE

AKEELA'S NOTICE OF PRIVACY PRACTICES

This notice describes how your protected health information (PHI), including substance use disorder (SUD) records protected by 42 CFR Part 2, may be used and disclosed, and how you can access this information. This notice is effective June 1, 2025 and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

1. Maintain the privacy of your protected health information, including sensitive records protected under HIPAA and 42 CFR Part 2.
2. Provide this notice outlining our privacy practices and your rights, as well as abide by the terms of this current Notice.
3. Notify you if a breach of unsecured PHI affecting you occurs, per HIPAA and Part 2 breach notification rules.
4. Reserve the right to update this Notice at any time. All changes will apply to existing and future records.

Use and Disclosure of Your Information

There are several situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment, and health care operations requires you to sign an Authorization. Certain disclosures are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure. Disclosures made under 42 CFR Part 2 will include a prohibition on redisclosure unless explicitly allowed by law.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our agency once you have provided consent.

We may use or disclose your PHI, including SUD treatment records, with your consent for:

Treatment: We will use your health information to make decisions about the provision, coordination, or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities and arranging for legal and auditing functions.

Health Information Exchange Organization

Federal and state laws permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes and such other purposes as may be permitted by law. You can **opt-in** for participation in this database.

Disclosure Without Consent

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law- enforcement activities, judicial and administrative proceeding and in the event of death. We may also be required to report instances of suspected or documented abuse, neglect, or domestic violence. We are required to report to appropriate agencies and law enforcement official's information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We may contact you from time-to-time to provide appointment reminders or information about treatment. We will try to speak quietly to you in a manner reasonably calculated to

avoid disclosing your health information to others. Specifically, there are eight reasons when we can disclose the minimum necessary client information:

1. Medical emergencies
2. Mandatory reports of child abuse or neglect
3. Threats to health or safety (suicidal or homicidal intent)
4. Court orders that comply with 42 CFR Part 2
5. Audits or evaluations by regulatory agencies or in the process of research
6. To report a crime committed on Akeela's premises or against Akeela's personnel
7. For de-identified research or public health purposes, when allowed by law
8. To qualified business associates with a business associate agreement in place

Patient Portal Privacy Practices

Akeela uses a secure electronic health platform, provided by OnCall Health (a Qualifacts company), to offer telehealth, messaging, and patient portal services. OnCall operates under its own privacy and security policies, which govern the handling of your information within the portal. When you register for the portal, you will be asked to review and agree to OnCall's separate privacy policy.

You have certain rights regarding your health information, as follows:

You may request that we restrict the uses and disclosures of your health record information for treatment, payment, and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to the above noticed exceptions, disclosures of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in civil, criminal, or administrative action or proceeding to which your access is restricted by law. We may charge a reasonable fee for providing a copy of your health records or a summary of those records at your request, which includes the cost of copying, postage, and preparation of an explanation or summary of the information.

All requests for inspection, copying and/or amending information in your health records and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment, and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period. If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you at your request.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer at Akeela, Inc. or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site:
https://www.hhs.gov/hipaa/for-individuals/index.html

All questions concerning this notice or requests made pursuant to it should be addressed to:
AKEELA, INC.
ATTN: PRIVACY OFFICER,
360 W. BENSON BLVD. SUITE 300, ANCHORAGE, AK 99503
PHONE: (907) 565-1200

AKEELA

CLIENT RIGHTS

At Akeela, we are committed to ensuring that every client is treated with dignity, respect, and fairness. The following rights are provided to help you understand what you can expect while receiving care with us.

1. Each client's rights are to be respected by Akeela and its staff.
2. A client has the right to get information supplied and explained in a manner understood.
3. A client has the right to be a part of the decision making and planning of treatment, care, or services.
4. A client has the right to give or withhold permission for recordings, films, pictures, videos, or other images of him/her to be taken or released for purposes other than their care.
5. A client's rights to be protected during research, investigation and clinical trials are to be respected by Akeela and its staff.
6. A client has the right to receive information on the staff providing care, treatment, or services, such as qualifications, gender, education, experience.
7. A client has the right to be free from neglect, exploitation, and verbal, mental, physical and sexual abuse.
8. A client has the right to be in an environment that preserves dignity and contributes to a positive self- image.
9. A client continues to have the right of all citizenship privileges including non-discrimination in receiving services.
10. A client has the right to access protective and advocacy services.
11. Akeela protects the rights of those served who work for or on behalf of Akeela.
12. Akeela staff will inform each client of their responsibilities related to their care, treatment, or services.
13. A client has the right to participate in formulating, evaluating and periodically reviewing their individualized written treatment plan, including requesting specific forms of treatment, being informed why requested forms of treatment are not made available, refusing specific forms of treatment that are offered, and being informed of prognosis.
14. A client has the right to review their treatment file with a staff member, at a reasonable time.
15. A client has the right to be informed by the prescribing physician of the name, purpose and possible side effects of any medication prescribed as part of their treatment.
16. A client has the right to request a written summary of treatment at time of discharge: that summary must include discharge and transition plans.
17. A client has the right for all of their information to be maintained confidentially and the right to give prior written approval for the release of identifiable information.

Some rights outlined in this document may be limited for clients participating in programs operated in partnership with the State of Alaska Department of Corrections (DOC), in accordance with DOC regulations, policies, and procedures.

If you believe your rights have been violated, please contact:

- YOUR Akeela Counselor, Program Manager or Director.
- You can always call Akeela's Compliance Hotline at 907-565-1200.
- You can also contact the Alaska Division of Behavioral Health, The Disability Law Center, or other organizations of your choosing.

AKEELA

ACKNOWLEDGEMENT OF
CLIENT RIGHTS and NOTICE of PRIVACY PRACTICES

I acknowledge that I have received a copy of Akeela Inc.'s Client Rights and Notice of Privacy Practices, and that I have had the opportunity to ask questions. My signature below confirms this receipt.

CLIENT SIGNATURE	**DATE**
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	**DATE**

TELE-BEHAVIORAL HEALTH CONSENT FORM

I, _____(name of client) hereby consent to receiving tele-behavioral health services from Akeela, Inc. ("Akeela"). I understand that tele-behavioral health is the provision of professional counseling services via a virtual delivery system, such as audio/video synchronous technology. The tele-behavioral health services will be provided through an internet-based platform and data is encrypted for high levels of protection and privacy. Tele-behavioral health services are provided by Akeela clinical staff and licensed professionals contracted by Akeela. Tele-behavioral health services may include evaluation, assessment, consultation, treatment and psychoeducation. Akeela clinical staff and licensed professionals contracted by Akeela who are trained in the use of tele-behavioral health will provide all tele-behavioral health services.

Technology: I understand that in order to receive tele-behavioral health services I must have reliable internet and a laptop, desktop, or tablet with a microphone and video. I may need to download an application and/or software to use participate in tele-behavioral health services. I understand and acknowledge that I will need access to, and familiarity with, the appropriate technology in order to participate in tele-behavioral health services. I further agree to comply with the Terms of Use and Privacy Policies of the technology platform utilized in my tele-behavioral health encounters.

Crisis/Emergency Policy: Tele-behavioral health sessions are considered outpatient services and are not a substitute for emergency or crisis services. I understand and acknowledge that an Akeela clinical staff member or licensed professional contracted by Akeela may not be available for contact between scheduled sessions. In the event of a crisis or mental health emergency, I understand that I should use my local crisis line, dial 911, or seek help from a hospital or crisis-oriented health care facility in my immediate area. I understand it is my responsibility to ensure my contact information and emergency contact information are kept up-to-date with Akeela.

Continuity of Care: Akeela will require a release of information before sharing my personal health information with my primary care physician, pediatrician, and any additional behavioral health providers or other outside agencies.

Confidentiality: I understand that the information disclosed by me during the course of my teletherapy services is confidential. However, there are mandatory and permissive exceptions to confidentiality including, but not limited to: (i) suspected child, elder, and/or dependent adult abuse; (ii) expressed threat of violence towards an ascertainable victim; (iii) expressed threat to harm or kill self; and (iv) court order / subpoena. I recognize that transmissions over the internet are at my own risk and that Akeela cannot guarantee the security of any information I transmit to them over the internet.

Rights and Obligations with Respect to Tele-Behavioral Health:

1. I have the right to withdraw my consent for tele-behavioral health services at any time without affecting my right to future care or treatment upon written notice to my Akeela treatment team.
2. I understand that Akeela has the right to discontinue services at any time upon written notice to me.
3. I acknowledge that no guarantee has been made to me regarding the effectiveness or result of evaluation and/or treatment.
4. I understand that I will need to provide Akeela with an emergency contact in case an emergency should occur while I am receiving services from Akeela.
5. I understand that tele-behavioral health services may not be as complete as in-person services. I also understand that if my Akeela treatment team believes that I would be better served by in-person services, arrangements will be made to begin in-person services, if available. If in-person services at Akeela are not available, I will be referred to another agency who can provide such services in my geographic area.
6. I understand the above-stated description of tele-behavioral health and consent to receive services through an internet- based platform. I will make every effort to maintain the security and privacy of my sessions. I release all Akeela professionals and entities from any liability should privacy or security be breached due to my failure to provide a private and secure session.
7. In the event that the client is a minor, I acknowledge and agree that a parent or legal guardian must be present during tele-behavioral health session(s).
8. This contract will be governed by the laws of the state in which I reside.
9. I understand it is my responsibility to notify my Akeela treatment team if I am receiving services in a state other than where I reside.
10. I understand that there are benefits, risks, and possible consequences associated with tele-behavioral health services, including, but not limited to, the possibility, despite reasonable efforts on the part of Akeela, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my treatment information could be accessed by unauthorized persons.
11. I understand that I have a right to access my treatment information and to obtain copies of treatment records in accordance with federal and state law.

I have read and understand the information provided above. I understand the risks, benefits and my rights related to tele- behavioral health services. I have discussed the information with my Akeela treatment team and all of my questions have been answered to my satisfaction. My signature below indicates that I hereby request and give my informed consent to Akeela's provision of tele-behavioral health services.

CLIENT SIGNATURE	**DATE**
CLIENT ADDRESS (Street, City, State, Zip Code)	**CLIENT'S PRIMARY PHONE NUMBER**

CONSENT FOR TECHNOLOGY-ASSISTED CLINICAL DOCUMENTATION

CLIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

PURPOSE OF THIS CONSENT

Akeela uses secure technology that may briefly capture audio during your sessions to help your provider document care accurately, reduce administrative burden, and support quality improvement. These recordings are only accessible to authorized staff within Akeela's highly secure electronic health record (EHR) system. This consent allows you to approve or decline this process. Your decision is voluntary and will not affect your ability to receive services.

SCOPE OF CONSENT

By signing this form, I voluntarily give permission to Akeela, Inc., including its affiliates, authorized staff, and contractors (collectively referred to as "Akeela"), to audio record my sessions for the purpose of secure clinical documentation, supervision, quality improvement, and treatment-related operations. These recordings, along with any transcriptions or digital content derived from them ("Audio Recordings"), may include my voice, statements, and other identifiable information related to my care.

Akeela uses software licensed from Qualifacts, our electronic health record (EHR) service provider, to securely process these recordings. This software may include the use of artificial intelligence (AI) tools to assist providers in drafting progress notes and improving documentation quality. All recordings are stored and handled in compliance with HIPAA, 42 CFR Part 2, and applicable state and federal confidentiality laws.

OWNERSHIP & USE OF RECORDINGS

I understand and agree that the recordings will be used solely for purposes related to treatment, clinical documentation, and internal quality improvement. All recordings will be securely stored and accessed only by authorized personnel. I acknowledge that I will not receive any compensation for the use of these recordings. Akeela retains ownership of all recordings and related materials but is under no obligation to use them.

CONFIDENTIALITY & PROTECTIONS

I understand that the information captured in these recordings is considered protected health information (PHI) and is subject to strict confidentiality requirements under HIPAA and 42 CFR Part 2. The recordings will not be used for marketing, research, training, or any non-treatment purposes without my additional written consent. Any use or disclosure of these recordings will comply with all applicable legal requirements, including the prohibition on redisclosure under 42 CFR Part 2 unless specifically authorized.

YOUR RIGHTS

Participation in recording is entirely voluntary and will not affect my eligibility to receive services from Akeela. I understand that I may revoke this consent at any time in writing; however, revocation will not apply to recordings that have already been made. I also understand that I may request a copy of Akeela's Notice of Privacy Practices, which provides information on how my health information is used and shared.

- ☐ **I CONSENT** and confirm that I have read and understood the information above.
- ☐ **I DO NOT** consent to be audio recorded for clinical documentation purposes. I understand that this will not affect my ability to receive services from Akeela.

CLIENT SIGNATURE	**DATE**
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	**DATE**

CONSENT FOR TREATMENT AND PROGRAM AGREEMENT

SECTION I: GENERAL

Please review each statement below and initial each statement indicating your acknowledgment and understanding.

_____ **CONSENT TO PARTICIPATE IN TREATMENT:** I hereby consent to receive behavioral health treatment from Akeela, Inc. I understand and agree to comply with program rules and conditions during my participation.

_____ **VOLUNTARY PARTICIPATION IN TREATMENT:** I understand that receiving behavioral health services from Akeela, Inc. is voluntary. I may withdraw my consent and discontinue services at any time. I also understand that I have the right to refuse any specific treatment recommendation without penalty.

_____ **INFORMED CONSENT TO SERVICES & TREATMENT CHANGES:** I understand that I will be informed of the nature, purpose, and expected benefits of all services provided. I will also be informed of any risks, limitations, and alternatives. Any changes to my treatment plan will be discussed with me before implementation.

_____ **RIGHT TO PARTICIPATE IN TREATMENT DECISIONS**: I understand that I have the right to participate in decisions regarding my care, including being informed of my treatment options, participating in treatment planning, and receiving services that align with my identified needs and goals.

_____ **CONFIDENTIALITY, INFORMED CONSENT, & LIMITS OF PRIVACY**: I understand that my treatment information is protected under the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2, which safeguard the confidentiality of behavioral health and substance use disorder treatment records. However, I have been informed that certain exceptions to confidentiality exist. Information may be disclosed without my written consent in the following situations, as allowed or required by federal and state law:

- In the event of a medical emergency
- To make mandatory reports of child abuse or neglect
- When there is a serious threat to health or safety, including suicidal or homicidal intent
- In response to a court order that complies with 42 CFR Part 2
- During audits, evaluations, or approved research conducted by authorized regulatory agencies
- To report a crime committed on Akeela's premises or against Akeela personnel
- For de-identified research or public health purposes, when legally permitted
- To qualified business associates under a binding Business Associate Agreement

I understand that in these cases, only the minimum necessary information will be disclosed, and efforts will be made to protect my privacy. I also understand that I have the right to be informed of how my information may be used and to request limits on disclosures when appropriate.

_____ **SUBSTANCE USE ABSTINENCE & DRUG TESTING AGREEMENT**: If enrolled in a substance use treatment program, I agree to remain abstinent from the use of any mood-altering chemicals (including alcohol or marijuana) other than those prescribed for me by licensed medical professionals during the course of treatment. I further agree to participate in random urinalysis testing. Upon request by program staff, I will provide a sample of my urine for testing/analysis.

_____ **UNDERSTANDING OF TREATMENT LIMITATIONS**: I acknowledge and understand that no promises or guarantees have been made to me regarding the outcome of my treatment by Akeela, and I hereby release Akeela, Inc. from liability if my treatment is unsuccessful.

_____ **RESPONSIBILITY FOR COSTS RELATED TO ACTIVITY INJURY/ACCIDENTS**: I have been advised that while I participate in Akeela, I will be responsible for all medical bills I incur due to injuries and/or accidents that occur while participating in social, sport, or other activities. I understand that participation in such activities is voluntary and not mandated by Akeela. I agree not to hold Akeela or its staff responsible for any injury unless negligence is involved.

_____ **AUTHORIZATION FOR POST-DISCHARGE FOLLOW-UP CONTACT**: I hereby authorize Akeela to contact me by mail, telephone, or in person after my discharge or graduation, as follow-up is an integral part of my overall treatment.

_____ **ACKNOWLEDGEMENT OF PRIVACY PRACTICE & CLIENT RIGHTS:** I acknowledge that I have received the Client Rights and Akeela's Notice of Privacy Practices and had the opportunity to receive an explanation and ask questions about them.

_____ **ACKNOWLEDGEMENT OF RESPONSIBILITY & BEHAVIORAL EXPECTATION:** I acknowledge that I may become aware of information about other clients during my treatment at Akeela. I agree to keep this information private and respect the confidentiality of others. I understand that maintaining the privacy of others is essential to creating a safe and respectful treatment environment.

SECTION II: ATTENDANCE

_____ **ACKNOWLEDGEMENT OF ATTENDANCE**: I acknowledge that I am expected to be on time for all scheduled group and individual counseling sessions. I understand that if I arrive late, I may not be admitted to the group session.

_____ **ACKNOWLEDGMENT OF TREATMENT EXPECTATIONS & CARE PLANNING**: I acknowledge that the level and duration of my services may change based on ongoing assessment of my treatment progress. I understand that any changes will be discussed by the treatment team and made in the best interest of my treatment.

_____ **ACKNOWLEDGEMENT OF EXTERNAL SUPPORT**: I acknowledge that if I am enrolled in a substance use treatment program, the treatment team may require me to attend external support groups such as Alcoholics Anonymous, Narcotics Anonymous, NAMI, or similar peer support groups as part of my treatment plan.

SECTION III: TREATMENT CHARGES

_____ **ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY**: I acknowledge that I am responsible for the cost of my treatment and agree to make financial arrangements with the Financial Office prior to starting my treatment program. I have been informed of all expected costs, billing procedures, and my financial responsibilities prior to receiving services. I understand I may request clarification about charges or financial arrangements at any time.

_____ **ACKNOWLEDGEMENT of PAYMENT EXPECTATIONS:** I acknowledge that all fees for services are due to and payable at the time of the service unless other arrangements have been made for me.

SECTION IV: MENTAL HEALTH EMERGENCY/CRISIS EVENT

If a Mental Health emergency crisis situation should arise and I am unable to reach my Akeela treatment team, I understand that I have an option to ask for help by contacting:

- **Providence Alaska Medical Center Crisis Line**
  - 907-563-3200 - available 24 hours/7 days per week
- **National Suicide Prevention Lifeline**
  - 988 (call or text) - available 24 hours/7 days per week
  - Alternate phone number is 800-273-8255

If you are not sure what type of emergency you are having, **call 911 immediately!**

_____ **ACKNOWLEDGEMENT OF MENTAL HEALTH OR CRISIS:** I acknowledge that I have received and reviewed Akeela's Mental Health Emergency information, including contact information for who to call in the event of a mental health crisis. I understand how to access support during the event and I understand that I am releasing my own confidential information when I call/text the hotline.

SECTION V: CLIENT GRIEVANCE PROCEDURES

All clients have the right to file a formal grievance if they believe that their civil and /or human rights have been violated by Akeela. Akeela staff will help any client file a formal grievance and assist the client in the procedures. All formal grievances must be filed in writing.

Procedures for Filing a Formal Grievance

1. Any client who believes that his or her civil and/or human rights have been violated will first discuss the incident with the Akeela employee(s) involved.
2. This meeting will take place within two (2) working days of the incident.
3. Another person will be selected by both parties to be present at this meeting. This person will act as a mediator.
4. This meeting will take place in private and remain confidential.
5. All attempts to resolve the grievance will be made during this meeting.

Written Grievance

If the grievance cannot be resolved in this meeting, the client may file the complaint in a written statement to the Clinical Director or designee. This written statement must be filed within five (5) days following the initial meeting. If the complaint involves the Clinical Director, the Executive Director will designate an impartial staff member to conduct the meeting.

The Clinical Director or designee shall meet with the client no later than five (5) days after receiving the written statement. During this meeting, the Clinical Director or designee will meet to resolve the grievance with the client. If the grievance is resolved during this meeting, no further action will be taken, but a written record of the meeting and outcome will be filed in the client's file and in an Administrative Grievance File.

Written Grievance to the Executive Director

If the client believes that the complaint has not yet been resolved, a written grievance may then be filed with the Executive Director or designee. This grievance must be filed within five (5) working days after the meeting with the Clinical Director or designed alternate.

The Executive Director or designee will inform the client both verbally and in writing of a final decision. The client will be informed of this decision within five (5) working days from the date of filing the complaint with the Executive Director. If a decision is not reached by the Executive Director or designee within this time frame, the client will be told the reason for the delay and a revised, mutually agreeable time will be adopted. However, the Executive Director or designee must make the final decision within thirty (30) days.

Appeal

The client may at any time notify the Division of Behavioral Health or the Joint Commission of the complaint. The client will be informed verbally and in writing of the results of the grievance procedures. Copies of the procedure's findings may be provided to any employee involved in the grievance proceedings. No client filing a grievance will be given punishment or harassment. Grievance procedure time limits may be extended by mutual consent between the client and Akeela Treatment Services. A full explanation of the policy and procedures for filing a grievance will be explained to the client before the formal procedures begin.

SECTION VI: CLIENT STATEMENT

My signature below confirms that I have read the above "Consent for Treatment and Program Agreement" and have had the opportunity to ask questions and receive explanations. I understand the meaning and implications of each item, and I voluntarily consent to the terms outlined. I affirm that I am signing this agreement freely, without coercion, and not under the influence of alcohol or other substances.

CLIENT SIGNATURE	DATE
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE	**DATE**

AKEELA

CLIENT MEDICAL RELEASE/EMERGENCY CONTACT INFORMATION

For your Safety, the following information will be kept in a secure area, accessible only to staff members, while you are attending treatment at Akeela. All information must be current in case of an emergency. Please complete the following:

I _____hereby give my consent to be given emergency medical treatment in the event of an accident, injury, or illness. I hereby release the Akeela and its representatives from any liability rising from an emergency in which it is deemed necessary to pursue medical treatment.

In case of an emergency Akeela may contact:

NAME	RELATIONSHIP	CONTACT PHONE NUMBER
1.		
2.		

List any of your medical information that would be important during an emergency.

DRUG/ALLERGIES	
MEDICATIONS	
OTHER MEDICAL CONDITIONS	

Is there an Advance Directive in place? ☐ YES ☐ NO

If you selected yes and have an Advance Directive, please provide a copy to Akeela staff for your health record and to give to emergency personnel.

By signing below, I authorize the above information to appropriate medical personnel.

CLIENT SIGNATURE	**DATE**
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	**DATE**

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT INFORMATION				
LAST NAME	**FIRST NAME**	**MIDDLE NAME**	**DOB**	**PHONE#**

I HEREBY REQUEST/AUTHORIZE RECORDS TO BE SENT:			
☐ TO ☐ FROM Must check one	**NAME OF PERSON/AGENCY**	**ADDRESS**	**CITY, STATE, ZIP CODE**

☐ TO ☐ FROM Must check one	**NAME OF PERSON/AGENCY**	**ADDRESS**	**CITY, STATE, ZIP CODE**
	AKEELA, INC	360 WEST BENSON BLVD	ANCHORAGE, AK 99503

TIMEFRAME FOR RECORDS: Specify the dates of service or time period for the records you want released.

START DATE or TIME PERIOD/YEAR:		**END DATE or TIME PERIOD/YEAR:**	

TYPE OF RECORDS TO BE RELEASED: Select the specific types of information you authorize for release. **INITIAL ALL** that apply.

INITIAL		INITIAL		INITIAL		INITIAL	
INITIAL	**Admission Assessment**	INITIAL	**Treatment or Discharge Summary**	INITIAL	**Progress Notes**	INITIAL	**Treatment Plan/Updates**
INITIAL	**Attendance History**	INITIAL	**Client in Treatment Confirmation**	INITIAL	**Lab/Drug Screening Results**	INITIAL	**Leave a Message for Client/Correspondence**
INITIAL	**Mental Health Only Assessment**	INITIAL	**Psychiatric Evaluation**	INITIAL	**Other** (specify):		

DELIVERY OF RECORDS: Please select how you would like your records to be delivered. Check ALL that apply

*Email poses privacy risks, consider carefully before authorizing.

☐ **Fax** (List Fax Number):	☐ **Verbal**	☐ **Exchange Information Between Parties**
☐ ***Email** (List Email Address):	☐ **Mail Documents**	☐ **I Will Pick up Records**

PURPOSE OF RELEASE: Check ALL that apply.

☐ **Coordination of Care**	☐ **Further Treatment**	☐ **My personal records**
☐ **Share with other health care providers**	☐ **Legal**	☐ **Other** (specify):

AUTHORIZATION ACKNOWLEDGEMENT & CONSENT: Please read the statement below carefully. By signing at the end of this form, you are confirming that you understand and agree to the terms described. This authorization will expire at the time of discharge from services or 12 months from the date signed, whichever is sooner.

I understand that my health records may include sensitive information such as diagnoses or treatment related to behavioral health, mental health, substance use, alcohol or drug treatment, and information related to HIV/AIDS. I understand that disclosing this information may be necessary to support coordination of care between providers. I acknowledge that choosing not to share this information may affect the quality or continuity of my care. I voluntarily authorize the use and/or disclosure of my health information as described in this release. I understand that this authorization is not required as a condition for receiving treatment, payment, enrollment in a health plan (if applicable), or eligibility for benefits. I understand that if the person or organization authorized to receive this information is not a health care provider or health plan, the information disclosed may no longer be protected under federal privacy laws. However, I also understand that certain types of information, such as substance use treatment records, may still be protected under federal or state confidentiality laws and must continue to be kept confidential by the recipient. I acknowledge that my substance use treatment records are protected under federal law by 42 CFR Part 2 and under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164. These records may not be disclosed without my written consent, unless otherwise permitted or required by law.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to any information that has already been disclosed or actions already taken in reliance on this authorization prior to the date the revocation is received. To revoke this authorization, I must submit my request in writing to Akeela by mail at 360 W. Benson Blvd. Suite 300, Attention: Privacy Officer, Anchorage, AK 99503, in person, or via secure portal message.

CLIENT SIGNATURE	**DATE**
CLIENT GUARDIAN/REPRESENTATIVE SIGNATURE (if applicable)	**DATE**

RECIPIENT INFORMATION - REDISCLOSURE NOTICE: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2. (ii) You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or (iii) You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).