THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

INTAKE FORMS

Forms:

- ☐ HTP Treatment Contract
- ☐ HTP Financial Agreement
- ☐ HTP Insurance Billing
- ☐ Credit Card on File Form
- ☐ Medical and Psychiatry Department Welcome Note to Parents
- ☐ Medical/Psychiatric Care While at HTP
- ☐ Parent Consent for Administration of Medication
- ☐ Nutrition Department Welcome Note to Parents
- ☐ Attendance Policy
- ☐ Consent to Treat Minors
- ☐ Informed Consent for Working With Therapist Associates
- ☐ Activity Release
- ☐ Drop-Off/ Pick-Up and Driving Permission
- ☐ Notice of Privacy Practices
- ☐ Email Communication Terms
- ☐ Arbitration Agreement
- ☐ Consent for the Use of Anonymous Data
- ☐ Consent for Use of Creative Work
- ☐ Suggested Items to Bring to HTP
- ☐ Tips That Many Parents Report Useful When Refeeding Their Child - From "Surviving FBT"
- ☐ Family Support Group Flyer

FOR OFFICE USE ONLY:

Reviewed by: Date

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

HTP TREATMENT CONTRACT

Client Name: _____ Date of Birth: _____

1. I acknowledge that the more I put into my treatment at HTP the more recovery I will achieve. I therefore agree to attend program on the days/times recommended by my treatment team. I will actively participate in individual, family and group therapy sessions. I will actively participate in dietitian and psychiatrist appointments as needed.
2. I will arrive on time for the program and stay until the end of the treatment day. I will sign in and out as I arrive and leave. If I feel I need to leave program before the day is over I will check in with a clinical staff member first. I will schedule non-HTP appointments on days/times when that does not conflict with HTP program. I will not take vacations while in the program unless approved by HTP treatment team. While vacations can be relaxing in general, for teens with eating disorders they tend to be stressful and result in a relapse of eating disorder behaviors. Repeated tardiness and any unexcused absences will be reviewed by my treatment team and may result in a reevaluation of treatment plan.
3. I understand that contact with other HTP group members outside of program is not recommended and I agree to let the treatment team know of any communication or contact with other HTP members outside of program.
4. I agree to follow all meal guidelines and understand that I need to consume a supplement(s) for any unfinished food. I further understand that I may not leave the group or go to the bathroom unsupervised for one hour following a meal or snack. If I repeatedly struggle with finishing meals then my treatment team may recommend a higher level of care.
5. I understand that the homework I am given will help facilitate my recovery and personal growth and I agree to actively participate in my recovery by completing all homework and assignments. I understand that if I do not complete homework assignments I may be asked to complete a behavioral chain analysis in order to reflect on what interfered with my ability to complete assignments or to stay after program to complete assignments.
6. For therapeutic reasons my weight will not be disclosed to me. If there is a concern about me going out of my healthy weight range my treatment team will discuss appropriate treatment adjustments.
7. I agree to help make HTP an environment that supports emotional safety, is respectful of individual difference and is free of maladaptive eating behaviors. I understand that it is important to maintain a pro-recovery environment and I agree to encourage and support other group members in their recovery. Name calling, swearing and aggressive acts will not be tolerated and may result in immediate discharge from group.
8. I agree to refrain from engaging in self-injurious behaviors and will practice alterative coping skills. If I am struggling with self-injury I agree to seek individual support from a clinical staff member (therapist).
9. I understand that when I begin HTP I may need to refrain from some physical activity /exercise which may include competitive sports in order to give my body a chance to heal. I understand that any physical activity/sports will be approved by the HTP medical team and will be based on my medical stability and general progress in the program. Any physical activity/exercise will be gradually integrated back into treatment plan as appropriate to my recovery.
10. I agree to refrain from using drugs, or alcohol both during and outside of program while in HTP. I understand that I may be randomly drug tested and that any positive test results or disclosure of drug/alcohol use by self or others of use may result in parental notification and repeated use may result in a referral to chemical dependency services. I understand that there is no smoking inside or on the patio at HTP.

THE HEALTHY TEEN PROJECT

A Place For Adolescent Eating Disorder Recovery

11. I understand that my HTP treatment team will communicate information regarding my treatment and progress with any outside treatment providers (with appropriate signed release of information form).
12. I understand that while it is normal have mixed feelings about recovery I agree to make a commitment to the recovery process and myself. I will discuss any mixed feelings I have with the clinical staff and I understand that if I do not follow this contract and program guidelines my treatment plan will be reevaluated and I may be dismissed from program or my treatment team may recommend a higher level of care.
13. I understand that what I talk about in group and with HTP staff is confidential. I agree to keep the confidentiality of other group members by not sharing what is said in HTP with others outside of program. While the details of my treatment will be kept confidential I understand that my parents will be updated regarding my progress and any major treatment issues. I further understand that if I am at risk of harming myself or someone else, or if staff becomes aware that a child, elderly person or dependent adult is at risk of being harmed that staff obligated to contact the appropriate authorities.
14. I agree to follow the dress code while I am HTP. This includes wearing clothes that are not overly revealing (tube/low cut tops, midriff revealing tops, spaghetti strap tops, short shorts, and jeans that are low cut at waist/rear). Graphic T's with neutral or pro recovery messages are permitted. If HTP staff feels my clothing is inappropriate in above ways I will be asked to wear alternate clothes or a hospital gown.
15. During the course of treatment HTP staff may plan walking trips to local restaurants/stores for the purpose of expanding food choices and practicing normative eating experiences. I therefore give permission for my daughter/son to leave HTP with HTP staff during the course of treatment. I release The Healthy Teen Project from any legal responsibility and liability for my child while on these outings.

_____ _____

Client Signature Date

_____ _____

Parent Signature Date

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

FINANCIAL AGREEMENT

Thank you for trusting The Healthy Teen Project (hereinafter referred to as "HTP") as a partner in your health care. It is our hope that the following financial agreement will help you understand your financial responsibilities (as well as those of your insurance provider) for services provided by HTP.

For PPO or Plans with "Out-of-Network" Benefits

HTP is considered "in-network" with Anthem Blue Cross, Health Net and Aetna. HTP is considered "out-of-network" with all other insurance providers. We understand the significant financial impact that eating disorder treatments can have on our patients and their families. Therefore, we strive to limit your out of pocket expenses by working with you and your insurance provider.

A "benefits review" occurs prior to program admittance and determines whether our services are included as a part of your healthcare benefits package. "Preauthorization" occurs at the onset of treatment and is the process whereby we request formal authorization for our services from your insurance provider. These processes are handled between HTP and your insurance company. Through the benefits review and preauthorization, we can usually fully understand the financial impact of program enrollment based on your insurance benefits.

When "out-of-network" rates apply, HTP makes every attempt to ensure a "single case agreement" (or "SCA") with your insurance plan. The SCA means that HTP is temporarily "in-network" for treatment, your in-network benefits apply and an agreed upon program rate is determined prior to treatment. Your assistance may be required to facilitate the process.

We can then disclose what you are likely to pay given your insurance benefits: deductible, coinsurance, and copay. If there are multiple insurance companies involved, it is more difficult to give an accurate assessment due to benefit overlaps.

Once enrolled, HTP bills your insurance provider on your behalf. Meaning, HTP submits the claims to your insurance company and assists with facilitating the processing of claims. Once processed, the payment is typically issued from your insurance provider directly to HTP. At times, however, an insurance payment might be sent to you directly rather than to HTP for services rendered. If that occurs, you are responsible for reimbursing HTP the full amount of that payment within 10 business days of receiving the processed claim.

For HMO plans

HTP makes all attempts to ensure a SCA with your insurance plan, as most HMO plans do not offer HTP's services within their plans and must outsource this benefit. Your assistance may be required to facilitate the process. In the event a SCA cannot be attained, HTP will provide a discounted cash payment option.

For Insurance Plans with no Out-of-Network Benefits

HTP will offer a cash daily rate for its program services, if needed.

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

HTP's Scope of Services

HTP's treatments/services include:

1. All group therapies
2. Individual sessions with an individual therapist
3. Individual sessions with a family therapist
4. Individual sessions with a dietitian
5. Supported meals and snacks (patient can provide their own food)

HTP treatment/services do NOT cover:

1. Individual medical appointments
2. Any medical tests
3. Any medical labs (blood tests) or other diagnostic tests (i.e. ECG)
4. Individual psychiatric appointments
5. Any neuropsychiatric testing that may be recommended for diagnostic purposes

Medical and Psychiatric Services

HTP offers professional medical, psychiatric, laboratory and other therapy services on site through the Community Health Collaborative. These services, however, unless specifically listed under HTP's Scope of Services section, are not included in this agreement.

Initial Medical and Psychiatric Assessments

Due to the higher acuity of many of our clients, HTP's admission process requires initial medical and psychiatric assessments by on-site medical providers affiliated with HTP through the Community Health Collaborative. These appointments are not part of HTP's Scope of Services and will be billed to your insurance company on your behalf.

Payment

Your policy is a contract between you and your insurance company and you have the final financial responsibility for paying HTP bills. Balance bills will be reconciled once actual payments from the insurance company are received.

Financial hardship can be evaluated on an individual basis. With hardship, we require proof of income (i.e. most recent tax return and W2s) to document the reason for assistance.

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

Policy for Missed Days of Treatment or if a patient is late for treatment

Because a large amount of HTP's staff time is reserved for each patient, we will charge for missed days of treatment at a rate of $400.00 per day if not notified within 24 hours of the missed time. If your child misses a portion of the treatment day, the day may not be covered by insurance and a missed day fee may apply. Multiple missed program days may result in discharge from the program.

If your child is more than 30 minutes late, we reserve the right to send your child home and consider it a missed day of treatment with the applicable fee of $400.00 per day.

Finance Charges

HTP reserves the right to assess finance charges and take additional collection measures on balances more than 30 days overdue. HTP will charge a 3.0% transaction processing fee for any credit card payments exceeding $2,500.

Returned Check Fees

There is a $50 administrative fee for each returned check.

Assignment of Benefits

You agree to assign to HTP the rights and interest in benefits payable to you for HTP's services rendered. In addition, you acknowledge and accept that you are responsible for paying HTP's charges in full and agree to forward any monies sent to you by your insurance provider for HTP's services.

You agree to allow HTP to release to your insurance carrier and its agent any and all information needed to determine the benefits payable under your coverage. Furthermore, you agree to authorize your insurance company and its carrier to release any information necessary for payment of charges incurred.

Acknowledgement of Receipt

By signing this form you acknowledge receiving, understanding, and agreeing to the terms of this Financial Agreement and your responsibilities associated with payments for your account, regardless of the insurance coverage you have. You understand that you will be billed and held responsible for any copayment, coinsurance, and/or deductible that are applicable based on the terms of your insurance benefits. This constitutes the entire financial agreement between HTP and you. No modifications to this agreement can be made orally and photocopies of this agreement are as valid as the original.

_____	_____	_____
Patient or Parent/Guardian Signature	Printed Name	Date

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

INSURANCE BILLING

Thank you for choosing The Community Health Collaborative and/or The Healthy Teen Project for your healthcare needs. We are providing the following summary to help you understand our billing process, the Explanation of Benefits ("EOBs") that you will receive from your insurance provider, and your resulting financial responsibility.

Medical and Psychiatric appointments will be billed to your insurance using your Out of Network ("OON") benefits. Your insurance provider will apply the appropriate OON deductibles, copays and coinsurance responsibilities to the claims we submit and subtract the portion that you owe from the payment that is made to us.

Key Terms:

- EOB ~ Explanation of Benefits
- Dates of Service ~ Date that service was performed
- CPT Code ~ Insurance billing code for service provided (you should find similar codes on the Explanation of Benefits ("EOB's") that you receive directly from your insurance provider.
- Procedure ~ brief description of service provided
- Billed charge ~ the amount we submitted to your insurance provider for this service
- Insurance Payment/Allowed amount ~ the amount your insurance provider paid for this service
- Note ~ your insurance provider's note explaining the reason you are responsible for a portion, or all of this payment ~ typically deductible, copayment or coinsurance.

Out of Network Benefit Information as of: / /

- Individual Deductible: $
- Family Deductible: $
- Individual Out of Pocket Max: $
- Family Out of Pocket Max: $
- Coinsurance: /
- Coinsurance once Deductible and Out of Pocket Max has been met:

Some insurance providers send payment directly to the subscriber, you. If you receive payment from your insurance provider for services provided to your child by the Healthy Teen Project/Community Health Collaborative, then please bring these payments and all pertaining documents to Diana Iniguez in Suite 200. Diana will happily review and discuss the contents of the EOBs with you. We find it most straight forward for everyone involved when you endorse over any insurance payments you receive to The Healthy Teen Project or The Community Health Collaborative. These payments will be applied to your account and you will receive a monthly statement reflecting these payments and your resulting financial responsibility.

_____

Signature Date

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

CREDIT CARD ON FILE POLICY

The Community Health Collaborative and The Healthy Teen Project require a copy of your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. A copy of the credit card receipt will be mailed to you if we charge your account. A 3.0% transaction processing charges will be added to any credit card charges exceeding $2,500.

I authorize The Community Health Collaborative and/or The Healthy Teen Project to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Cardholder Name: _____

Credit Card Number: _____

Expiration Date: _____ / _____ / _____

CVV: _____

Billing Zip: _____

I, the undersigned, authorize and request The Community Health Collaborative and/or The Healthy Teen Project to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by The Community Health Collaborative and/or The Healthy Teen Project. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to The Community Health Collaborative and/or The Healthy Teen Project in writing and the account must be in good standing.

Name (Print): _____

Signature: _____

Date: _____ / _____ / _____

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

MEDICAL AND PSYCHIATRY DEPARTMENT WELCOME NOTE TO PARENTS

As you prepare for your teen's admission to HTP, here are some answers to Frequently Asked Questions as well as guidance regarding what to bring on the first day of program:

- Please bring ***all*** of your child's medications in the original containers ***on the day of admission*** including prescribed, over-the-counter and/or non-prescribed medications and/or any supplements.
- Please know that on the day of your child's admission, parents will need to sign a consent for any medications or supplements that need to be administered during program hours.
- ***Authorized activity during the first two weeks of HTP's Program is "restful."*** No exercise is authorized (unless discussed differently) ***until fully assessed by your child's medical provider and/or until the first treatment Team meeting with parents.***
- If possible, please obtain documentation from your child's Pediatrician or recent medical provider(s) to include:
    - Growth Curves: a copy of your child's most complete Growth Curves.
    - Labs/Diagnostics: please provide your child's most recent bloodwork and EKG results and/or any other relevant testing including Psychological or Genetic Testing.
- Please anticipate that we will be ordering comprehensive bloodwork following your child's admission (unless discussed differently). Depending on your child's medical presentation, we may be requesting routine or intermittent bloodwork going forward. We will be providing guidance for these blood draws including a Lab Requisition (aka "Order"); ***please complete your child's blood draw within 1-2 days of receiving a Lab Requisition from an HTP Medical Provider.***
- Medical and Psychiatric updates to Parents will typically be provided weekly (via email, in-person or by telephone) unless indicated otherwise.
- Should you provide your child with any "as needed'' over-the-counter medications or supplements (eg. Advil) ***outside of program***, please communicate this to your child's HTP Medical Provider as soon as possible. Conversely, we will notify you of any "as needed" medications that we administer to your child during program hours (that you have provided prior consent) as soon as possible.
- You may reach out to your HTP Medical or Psychiatric providers by email or phone at any time during your child's admission to HTP. You will receive their direct emails in your initial HTP "Welcome" email. If you prefer to contact your child's provider by phone, please call HTP's Receptionist and Administrator, Kim Krichbaum at 650 941 2300 to coordinate.
- On the day of your child's admission, please know that you will be meeting with our Billing Administrator, Diana Iniguez, to discuss HTP's medical and psychiatric billing policies.

_____ _____

Client Signature Date

_____ _____

Parent Signature Dat

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

MEDICAL AND PSYCHIATRIC CARE WHILE AT THE HEALTHY TEEN PROJECT

Client Name: _____ Date of Birth: _____

Medical and Psychiatric complications from eating disorders can be significant; therefore, all clients at The Healthy Teen Project, Inc. (hereinafter referred to as "HTP") are required to have close medical supervision while they are enrolled our programs. The HTP medical provider working with your child will determine the appropriate frequency of medical visits. This will most likely be once or twice a week. Psychiatric monitoring will depend on each client and you may choose for your child to be seen here or by their current psychiatric provider.

You may choose to have your child medically/psychiatrically monitored by another medical/psychiatric provider and not use the on-site medical/psychiatric services provided through the Community Health Collaborative. If you choose this option, we will need a signed reciprocal release with that doctor/psychiatrist so the medical providers at HTP who will be overseeing your child's medical condition can speak with your child's doctor. If you choose this option you are agreeing to have your child checked by his/her doctor at the frequency recommended by HTP's medical providers. Your child's doctor must also communicate all pertinent medical information to HTP in a timely manner.

Should you elect to have your medical/psychiatric care provided by the Community Health Collaborative, please note that these services are not included as part of the HTP program fee. The professional fees associated with this medical/psychiatric care will be submitted to your insurance provider just as if you were seeing another outpatient provider. While we bill insurance on your behalf, you are responsible for the payment of these charges and any payment deficit that results from the difference between the payment(s) made by your insurance provider and the billed amount submitted **(Initial ____)**. If you have any questions or would like more information about the fees associated with medical services please contact Diana Iniguez directly at (650) 935-4111 or diana@healthyteenproject.com.

If we do not receive a medical update from your child's doctor in a timely manner we will check your child's vital signs at HTP. The charge for this service is $150. This cannot be submitted to your insurance company for reimbursement. This vital sign check gives us some information about how your child is doing medically, but does not replace a full medical visit. If we do not receive a medical update from your child's doctor in a timely manner a second time we will again check your child's vital signs at HTP for a charge of $150. At that time, however, we will discuss if it is appropriate for your child to continue to get their medical monitoring from their own doctor.

I choose to have the following medical/psychiatric care for my child/myself:

☐ HTP – Medical/Psychiatric appointments will be scheduled during Program Hours

☐ My/my child's doctor/psychiatrist - Please fill out the doctor/psychiatrist information below and sign a release of information so HTP can communicate with the doctor.

Doctor's Name: _____ Psychiatrist Name: _____

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

Phone Number: _____/_____ Fax Number: _____/_____

By signing below I am stating that I understand the information above.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Client

_____ _____
Diana Iniguez Date

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

PARENT CONSENT FOR ADMINISTRATION OF MEDICATION

This form is to be completed for each medication to be administered during program hours.

Patient's Name: _____ DOB: _____

- I authorize that medical and non-medical personnel supervise in the administration of medication to my child/self according to the instructions below. I understand that:
- There may be instances where medication *may be administered by non-medical personnel*.
- Prescription and over the counter medications must be stored in the original bottle with unaltered label, Pharmacists can provide a duplicate labeled container.
- Prescription and over the counter medication shall be administered in accordance with the label directions.
- Written consent must be provided from the parent or adult patient, permitting the Healthy Teen Project medical/non-medical personnel to administer medication to the patient. Instructions shall not conflict with the prescription label directions.
- It will be the responsibility of the parent/guardian/adult patient to inform the Healthy Teen Project of any changes. New medications or new doses will not be given unless a new form is completed and newly labeled container is provided.
- All medication will be given directly to the Healthy Teen Project.
- Unused medications MUST be picked up by parent/guardian/adult patient within one week after patient has been discharged or medication will be disposed (unless other arrangements have been coordinated).

Name of Medication: _____

Dose: _____ Route (Oral, topical, tec.): _____

Time to be given: _____

Condition/Illness requiring Medication: _____

Possible side effect: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize that medical and non-medical personnel of the Healthy Teen Project to assist my child/self in taking prescribed and/or OTC(Over the counter) medications according to the directions given and I release them from any liability for administering the medication. I understand that in the event of a change in medication I am responsible for presenting a new request form.

Parent/Legal Guardian/Adult Patient Signature: _____Date: _____

Pharmacy Preference: _____ Pharmacy Phone: _____

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

NUTRITION DEPARTMENT WELCOME NOTE TO PARENTS

As you prepare to bring your teen to HTP, we know that you may have a lot of nutrition-related questions. In the first 1-2 days of admission, you and your teen will be meeting with one of our Registered Dietitians who will provide detailed guidance on what to feed your teen. In the meantime, we thought it would be helpful to provide a brief overview of what to send on the first day. If your teen is currently seeing a Registered Dietitian in the outpatient setting, you may follow their recommendations and send meals per their individual plan. Please note that we provide snack every day and dinner from a restaurant on Wednesday nights so you will not need to send food for those specific meals.

Nutritional Needs that Will Need to be Met in Program/What to Expect:

- Depending on which hours your teen will be attending program, please pack either lunch (early IOP) or dinner (late IOP) or both (PHP).
    - Lunch 12:15-12:45pm
        - Include foods from all of the following food groups (grains, protein, dairy, fats, fruits/veggies)
        - We can provide juice or milk with this meal if needed
        - Ex) Turkey & cheese sandwich with mayo or avocado, lettuce, tomato + crackers or chips + fruit
    - Snacks 3:05-3:20pm
        - Provided by HTP daily—Do not pack snack. These foods include a mix of whole foods and processed foods (items that contain refined sugar, items that contain preservatives, etc).
        - Snacks at home should include two food group items per your individual meal plan
        - Ex) Cheese and crackers
    - Dinner 5:15-5:45pm
        - Include foods from the following food groups (grains, protein, dairy, fats, fruits/veggies)
        - We can provide juice or milk with this meal if needed
        - Ex) Spaghetti with meat sauce + salad with dressing + bread roll with butter
        - Teens are not required to come to program with dinner on Wednesdays and Fridays:
            - Experiential dinner occurs 1x/week on Wednesdays where we bring items in from restaurants.
            - On Fridays, program ends early (5 pm) and teens will eat dinner with their family.

- Unfinished Meals/Snacks: your child will be given 10 minutes at the end of the meal/snack time to replace any unfinished food with Boost Plus.
- Teens will participate in Monday's nutrition experiential group with a Registered Dietitian where snacks are created with your teen and vary to include items such as brownies, chips and guacamole, cookies, rice krispy treats, pita chips and hummus, granola bars, etc).
- While in program, teens are asked to stick to decaffeinated and non-carbonated beverages unless advised otherwise by their individual treatment team.
- The nutrition philosophy is an "all foods fit" approach in supporting your teen through recovery. Exceptions can be made for medically diagnosed allergies and religious/cultural food beliefs.

THE HEALTHY TEEN PROJECT

A Place For Adolescent Eating Disorder Recovery

Please note that we will provide dishware, utensils, and napkins. We have numerous microwaves for re-heating meals as well as a toaster oven and a panini press which your teen will be welcome to use as needed. We have two refrigerators to store food in throughout the day and clients are asked to take their Tupperware/food bags home at the end of each program day.

_____ _____

Client Signature Date

_____ _____

Parent Signature Date

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

ATTENDANCE POLICY

All clients are required to attend the entirety of their scheduled treatment days. If a client expects to miss a day or part of a day for an outside appointment, they must receive approval at least 24 hours in advance directly from their primary therapist. Medical appointment changes should be made directly with our receptionist.

Absences (for any reason) without advance 24-hour notification and approval will be considered unexcused. Unexcused absences may result in a $400.00 charge per day of missed treatment. Absences due to vacations need to be discussed with your team well in advance and may result in change in coverage by your insurance company.

Illness Policy:
If client does not feel well enough to attend a scheduled appointment then client is required to have a same day phone appointment with the HTP medical provider (Katie Bell, NP) in order to be excused from treatment and to help determine likely length of time out of program for this illness. If client does not follow the above procedure, then their absence will be considered unexcused.

Late Arrival Policy:
Clients arriving more than 15 minutes late for program without prior approval may be charged a late fee of $25.00.

Appointments more than 15 minutes late with HTP providers (individual, family, medical and psychiatric) may also be charged a late fee of $25.00 and may be subject to rescheduling for a different time and/or day.

Pick Up/Drop Off Policy:
Unless otherwise arranged, all PHP clients arrive at 11:30 and IOP clients (unless "early IOP") arrive at 2pm. Program ends at 6pm, except Friday ends at 5pm (early IOP ends at 3:30). To ensure that all meals are delivered without being tampered with, parents generally escort clients into program and handoff meals and meal sheets to staff. We request that parents or guardians come into the program to pick up their family member. All clients must sign in and sign out at the front desk each day. Clients that are driving themselves to/from ARE NOT ALLOWED TO DRIVE THEMSELVES FOR THE FIRST TWO WEEKS and must have parental consent.

Late Pick Up Policy:
Clients picked up more than 15 minutes after the end of the daily program will be charged a late pick up fee of $25.00 for every 15-minute interval that they are late.

Multiple (3 or more) or repeated episodes of absences will result in evaluation of the client and their family's ability to attend treatment in an effective manner and other treatment options (including discharge from HTP) may be recommended.

I have read, understand and agree to the above policies.

Parent Signature:_____ Date:_____

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

CONSENT TO TREAT MINORS

Client Name: _____ Date of Birth: _____

It is essential that all parents who have legal custody over this child, whether or not they are married, give written permission for this child's mental health treatment. If parents are divorced, they may be asked to bring a copy of the court order, which addresses the issue of legal custody for the therapy records. Consent may be given for children in foster care by their court appointed legal guardians or by the Department of Social Services.

I/We give permission to The Healthy Teen Project ("HTP"), to provide mental health services to my/our child.

Name: _____ Date of Birth: _____

- I understand that his/her treatment is confidential, but that HTP will include the parents whenever it is clinically appropriate.
- I am willing to participate along with my child as needed.
- I understand that I am encouraged to ask any questions I have about anything on this form. I understand that I should not sign this form if there is anything I do not understand.

_____ _____

Signature of Parent/Guardian Date

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

INFORMED CONSENT FOR WORKING WITH THERAPIST ASSOCIATES

Patient Name: _____ Date of Birth: _____

This document is intended to provide important information to you regarding your treatment, that is in addition to the *Notice of Privacy Practices.*

The Healthy Teen Project is a training facility that employs therapist associates and psychological assistants. A therapist associate is trained clinician who holds a Master's degree in the field of psychology or social work, whereas a psychological assistant is a doctorate-level trained clinician. Both are in the process of completing their post-degree hours towards licensure. The therapist might be an Associate Marriage and Family Therapist, Associate Professional Clinical Counselor, Associate Clinical Social Worker, or Psychological Assistant.

As required by the California Board of Behavioral Sciences, all pre-licensed therapists are supervised by a licensed clinical supervisor. The supervisor has additional training and is licensed by the State of California to provide clinical supervision. The supervisor will periodically review your counseling sessions in an effort to ensure the best care possible. The review may include discussion, notes, and feedback to your associate therapist.

By signing below, you acknowledge that you have read and understand this agreement.

_____ _____
Client Signature Date

_____ _____
Parent/Authorized Representative Signature Date

_____ _____
Staff Signature Date

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

ACTIVITY RELEASE

Client Name: _____ Date of Birth: _____

The Healthy Teen Project (hereinafter referred to as "HTP") conducts activities for its clients which may require physical activity (such as walking to a café for a meal outing or grocery store outing). In connection with these activities, HTP requests that you sign the following release:

"I understand that participation in the activities sponsored by HTP may *expose me to a potential risk of injury, including but not limited to, which may occur in the usual course of such activities. In consideration of the right to participate in the program, I voluntarily assume such risk, and hereby release HTP, its agents and employees from any and all liability arising from my participation."*

_____ _____
Client Signature Date

_____ _____
Parent/Authorized Healthcare Representative Signature Date

_____ _____
Staff Signature Date

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

DROP-OFF / PICK-UP AND DRIVING PERMISSION

Client Name: _____ Date of Birth: _____

Drop-off / Pick-up permission:

I, _____ , give my permission for my son/daughter, named above, to be dropped-off and picked up at The Healthy Teen Project by the following individuals:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

I understand that employees of The Healthy Teen Project will not provide transportation for me except on special occasions in which they obtain my consent first.

_____ _____
Parent/Authorized Healthcare Representative Signature Date

Driving Permission:

☐ Check box if not applicable

I, _____ , give permission for my son/daughter, named above, to arrive and leave The Healthy Teen Project without a parent/responsible adult. My son/daughter is responsible for checking him/herself in and out upon arrival and departure at The Healthy Teen Project.

_____ _____
Parent/Authorized Healthcare Representative Signature Date

NOTICE OF PRIVACY PRACTICES

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION ("PHI")

We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when, and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of our program. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, we are legally required to follow the privacy practices described in this Notice.

However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to PHI on file with us already. Before we make any important changes to my policies, we will promptly change this Notice and post a new copy of it in the program office and on our website (if applicable). You can also request a copy of this Notice from us, or you can view a copy of it in our office or at our website, which is located at http://www.healthyteenproject.com.

III. HOW WE MAY USE AND DISCLOSE YOUR PHI.

We will use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior written authorization; for others, however, we do not. Listed below are the different categories of uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. We can use your PHI within our practice to provide you with mental health treatment, including discussing or sharing your PHI with program staff. We can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, we can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. We can use and disclose your PHI to bill and collect payment for the treatment and services provided by us to you. For example, we might send your PHI to your insurance company or health plan to get paid for the health care services that we have provided to you, or provide your PHI to business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. We can use and disclose your PHI to operate our practice. For example, we might use your PHI to evaluate the quality of health care services that you received. We may also provide your PHI to professionals such as accountants, attorneys, consultants, or others to further our health care operations.
4. Patient Incapacitation or Emergency. We may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. We can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, we may have to make a disclosure to applicable governmental officials when we are required by law to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim, we may have to use or disclose your PHI in response to a court or administrative order, or a subpoena.

3. When law enforcement requires disclosure. For example, we may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, we may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, we may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. Any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, we may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, we may have to use or disclose your PHI to remind you about your appointments, to give you information about treatment alternatives or other health care benefits that we offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, we will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action in reliance on such authorization) of your PHI by us.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on Our Uses and Disclosures. You have the right to request restrictions or limitations on our uses or disclosures of your PHI to carry out treatment, payment, or health care operations. You also have the right to request that we restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to us in writing. We will consider your requests, but we are not legally required to accept them. If we do accept your requests, we will put them in writing and will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that we are legally required to make.

B. The Right to Choose How We Send PHI to You. You have the right to request that we send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide us with information as to how payment for such alternate communications will be handled. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that we that we have about you, but you must make the request to inspect and receive a copy of such information in writing. If we don't have your PHI but know who does, we will tell you how to get it. We will respond to your request within 30 days of receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, we will charge you a reasonable amount for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures We Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which we have disclosed your PHI. The list will not include disclosures

made for treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before June 2013.

We will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section Vl below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact us at: 650-941-2300.

VII. EFFECTIVE DATE OF THIS NOTICE. This notice went into effect in June 2013.

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Client Name: _____ Date of Birth: _____

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that The Healthy Teen Project (hereinafter referred to as "HTP") has given to you. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

HTP's Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice from me by contacting us at 650-941-2300.

If you have any questions about this Notice of Privacy Practices, please contact HTP at:

919 Fremont Avenue
Los Altos, CA 94024
650-941-2300

I acknowledge receipt of the Notice of Privacy Practices of The Healthy Teen Project.

Signature: _____ Date: _____
(client/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HTP made good faith attempts to obtain our client's acknowledgement of his or her receipt of our Notice of Privacy Practices, including _____.

However, because of the following reasons_____

_____ we were unable to obtain our client's acknowledgement.

Signature of Provider: _____ Date: _____

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

EMAIL COMMUNICATION TERMS

Client Name: _____ Date of Birth: _____

Email is an efficient, convenient form of communication and can help to enhance your communication with the team at The Healthy Teen Project (hereinafter referred to as "HTP"). However, there are some innate limitations and risks to the use of email. This agreement will review the risks of email communication and will delineate what types of issues are appropriate and NOT appropriate for email. If after reading this agreement, you still have questions about the use of email in our practice, please address them directly with the team at HTP.

What are the confidentiality implications of email communication?

It is not possible to guarantee the confidentiality of email exchanges.

- If your email is through your employer, your employer may own and review all emails sent to that address.
- If your email address is a family address, other family members may see your messages.
- If you use an Internet Service Provider (ISP), there is a risk that messages may be intercepted by others.
- Emails sent to this practice may be viewed by others involved in this medical practice such as, but not limited to, a nurse or receptionist.

What happens to emails sent to HTP?

An electronic copy of the emails that are received by HTP are saved in the client chart.

What types of communication are appropriate for email?

It is appropriate to use email for **non-urgent matters only.** Although our team will do our best to read and reply to all emails promptly, it may take up to 48 hours to read and reply to an email. Also, occasionally emails do get lost in transmission due to problems with the ISP or human error such as a typo in the email address. If you do not receive a reply to your email in 48 hours, you should assume that it was not received and should re-send it. The following types of issues <u>are</u> appropriate for email:

- NON-URGENT medical or psychological matters
- Prescription refills
- Appointment scheduling. However, cancellations via email must be made at least 48 hours in advance. Cancellations via phone need to be at least 24 hours in advance.
- Billing or insurance questions

What types of communication are NOT appropriate for email?

The following subjects are <u>never</u> appropriate for email:

- Any urgent medical or psychiatric problem

- Any issue of a strictly confidential nature or where confidentiality needs to be assured
- Any situation where you or another are in risk of imminent harm (remember, the doctor may not see the email for 48 hours)

Email and HIPAA

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that email that contains protected health information be encrypted. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient or guardian provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

As a general practice, emails sent to you from HTP will be sent encrypted which will require you to login to our secure email system. Anyone who receives an encrypted email will be directed to the secure message portal, where the message can be retrieved. There is a one-time account setup for recipients; once an account has been created, messages can be read and replied to. Past messages will remain available inside the secure message portal as long as they haven't expired or been deleted.

Although encrypted electronic messaging is preferred to unsecure email messaging for communication of protected health information, unsecure email communication containing sensitive health information can be sent between a HTP provider and patient or guardian. This option is often preferred by clients in order to expedite the communication of daily updates regarding a client's treatment and progress. If box below is checked and this form is completed and signed by the patient or guardian, then unsecure email communication about the patient's medical care and treatment may be used to transmit information between the patient and HTP.

☐ I authorize HTP and its providers to use unsecured email to communicate with me regarding my/my child's medical care, behavioral health treatment and diagnostic results.

By signing this form, you acknowledge receipt of and your agreement to our *Email Communication Terms.* If you have any questions about our *Email Communication Terms*, please ask Diana Iniguez.

Acknowledgement of Receipt and Agreement: I acknowledge receipt of and agree to the *Email Communication Terms* as stated herein and understand that no modifications to this agreement can be made orally.

Signature _____ Date _____
Patient, Parent or Legal Guardian

Relationship to patient: _____

Email address you would like to use in communication with our practice: _____

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

A MESSAGE TO OUR PARENTS ABOUT ARBITRATION

Our goal is to provide medical care to our patients in a way that will avoid disputes. We know that most problems occur as a result of miscommunication. So, if you have concerns about your medical care, please discuss them with us.

Please read the attached contract entitled Physician-Patient Arbitration Agreement. By signing the contract, we are agreeing that any dispute arising out of the medical services you receive will be resolved in binding arbitration before an arbitration panel instead of by a lawsuit in a court of law.

Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

We believe that the method of resolving disputes in arbitration spares the parties some of the rigors, time and expense of a court trial.

Thank you,

The Healthy Teen Project

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant

to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient's Representative's Signature Date

_____
(If Representative, print Name and Relationship to Patient)

By: _____ _____
Authorized Representative's Signature Date

The Healthy Teen Project

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

CONSENT FORM FOR USE OF ANONYMOUS DATA FOR THE PURPOSE OF FUTURE RESEARCH at THE HEALTHY TEEN PROJECT

The Healthy Teen Project is currently administering questionnaires to aid in the assessment and treatment of eating disorders.

The following measures are being administered:

1. Eating Pathology Symptoms Inventory (EPSI), a 45-item measure of symptoms of pathological eating
2. Eating Attitudes Questionnaire-26 (EAT-26), a 26-item self-report measure of symptoms and concerns characteristic of eating disorders
3. Beck Youth Depression Inventory, a 20-item measure with statements addressing thoughts, feelings and behaviors that are used to identify symptoms of depression in children and adolescents
4. Beck Youth Anxiety Inventory, a 20-item measure used to identify anxiety in children and adolescents with statements addressing worries about school performance, the future, negative reactions of others, fears including loss of control, and physiological symptoms associated with anxiety
5. Rosenberg Self-Esteem Scale, a 10-item measure designed to assess self-esteem and self-worth
6. Family Environment Scale, a 90-item measure used to assess social and environmental characteristics of families.

Whereas we are not currently using these measures for research purposes, it is possible that HTP will use data gathered from these measures for research studies in the future. Before consenting to the use of your child's data from these measures for future research purposes, it is important that you understand the procedures, benefits, risks, and discomforts that may be involved.

The purpose of the use of these measures for future research would be to understand different variables that contribute to eating disorder recovery and how the Healthy Teen Project is doing in terms of facilitating eating disorder recovery. We will have your child complete these measures during the first few weeks of their treatment at the Healthy Teen Project.

Protection of confidentiality

All of the data obtained will be completely confidential and anonymous, such that your child's identity will be completely protected. We will enter the data from these measures into the computer anonymously, and your child's name will NOT be associated with the data from the questionnaire.

Potential benefits

In the event that HTP uses the data from these measures for research purposes, it may help us to understand different factors that contribute to eating disorder recovery and to improve eating disorder treatment approaches.

Potential Risks or Discomforts

There is no foreseeable discomfort or risk associated with participation in this study.

Voluntary participation

Allowing HTP to utilize data from these measures for potential research purposes is voluntary. You may choose not to let your child participate and you may withdraw your consent for your child to participate at any time. You will not be penalized in any way should you decide not to participate or to withdraw your consent.

Contact information

If you have any questions or concerns about this study or if any problems arise, please contact Katie Bell, NP at 650-941-2300.

Consent

I have read this consent form and have been given the opportunity to ask questions. I give my consent for my child to fill out the above-mentioned measures for the possible use in future research studies.

Parent's or Guardian's signature: _____ Date: _____

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

Consent Form for Use of Creative Work
For the Purposes of Community Outreach and Awareness

The Healthy Teen Project aspires to provide awareness to eating disorders in efforts to increase access to treatment and enhance preventative efforts. Part of these efforts include posting art and articles on social media and on our website's blog, and celebrating national events with organizations including National Eating Disorder Association (NEDA).

We want to welcome our clients and families to partake in these efforts by creating their own works of art while in program to be shared via social media and posted on our blog. Images and written work will be reviewed by Healthy Teen staff to assure that the content is appropriate for the audience, and most importantly, each client's confidentiality and privacy is upheld.

Protection of confidentiality
All of the creative works showcased will be completely confidential and anonymous, such that your child's identity will be completely protected. Your child's name will NOT be associated with the work of art unless additional, individualized consent is given by parent and client upon family's request.

Potential benefits
In the event that HTP uses the creative work for artistic displays during community outreach efforts, it may help us to fully represent the clients we treat and to improve community understanding of eating disorders, treatment, and recovery.

Potential Risks or Discomforts
There is no foreseeable discomfort or risk associated with showcasing anonymous creative works.

Voluntary participation
Allowing HTP to utilize creative work for outreach purposes is voluntary. You may choose not to let your child participate and you may withdraw your consent for your child to participate at any time. You will not be penalized in any way should you decide not to participate or to withdraw your consent.

Consent
I have read this consent form and have been given the opportunity to ask questions. I give my consent for my child to create and display their creative work under the close supervision of clinical staff at Healthy Teen Project.

Parent's or Guardian's signature_____
Date:_____

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

SUGGESTED ITEMS TO BRING TO HTP

- Comfortable loose fitting clothing (depending on the season): needs to follow general "school" dress codes re length of shorts/skirts. See Handbook.
- Light Jacket or sweater if you get cold, though big jackets not allowed at the dining table
- Notebooks/Journals
- Reading Books for any breaks
- Personal hobbies: i.e.-crochet, knitting, jewelry making
- "Comfort Items": favorite stuffed animals for example
- Current prescription or OTC medications you are taking in original containers (these will be placed in the medication room upon admission) with signed permission to take on premises

Items Not to Bring

- Anything eating disorder related such as: diet pills, laxatives, diet books, eating disorder related reading material, scales, etc.
- Cell Phones may be brought to HTP, but will be stored away during the duration of program
- Laptops or expensive items you do not want left in your cubby
- Pets

919 Fremont Avenue, Suite 100 ● Los Altos, CA 94024 ● www.healthyteenproject.com
650-941-2300 ● 650-941-2305 (fax)

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

TIPS THAT MANY PARENTS REPORT USEFUL WHEN REFEEDING THEIR CHILD - FROM "SURVIVING FBT"

- It's best to include **variety** and **fear foods** right from the **start** of refeeding, otherwise when you do introduce fear foods, it will be like starting over.

- Don't get caught in the trap that "healthy food" will get your child better. Anorexia is basically fear of food and, in particular, high density foods. You will know your child has recovered when they can eat everything without fear, and a good sign of recovery is when they can eat everything they ate prior to anorexia.

- At meal times **don't** get into the habit of **negotiating, convincing, lecturing or using logic.** It is likely to fail and it's a good tactic anorexia uses to waste/avoid refeeding time. Instead, **stick to direct prompting (over and over again)** to eat the food you provided your child at meal times as this will wear anorexia down.

- Be vigilant by sitting with and supervising your child to eat the whole meal you provide. Your child may hide food up sleeves, in pockets and in many places that will surprise you. They will do anything to avoid eating if given half the chance.

- Don't fall into the trap of giving your child what you think they will eat. This is accommodating your fear. Give them what they need to get healthy.

- Don't get your child involved in food preparation, planning, calorie counting with them, shopping or any decisions involving food as their current focus will be on the reduction of calories and eliminating fear foods. Just put the meal in front of your child and provide support.

- Ensure you know how much your child needs to eat to gain weight and the foods that will achieve good weight gain. While parents are usually very good at knowing what to feed a healthy child, they need to learn quickly how much to feed a starving child.

- **Don't expect that your child will be able to make decisions about what to eat.** Their thinking is too compromised to do this and they will feel guilty with whichever decision they make. They are in a "no-win" situation and will be relieved when someone makes the decision for them.

- Try not to talk about healthy eating, but talk about normalized eating. Normalized eating is what the average healthy adolescents does - **eats variety eats regularly, is flexible and eats with enjoyment and without fear.**

- Try and stop all the anorexia behaviors at meal times as quickly as possible (i.e. breaking food into small pieces, eating with a teaspoon, etc) as these behaviors strengthen anorexia. Every time you **push your child past their fear boundary** it will get easier for them (it's like exposure therapy).

- Be prepared for resistance and a battle with the anorexia. **There will be a battle until your child gets the message and believes that you are stronger than the anorexia and that you will not budge** because you will not let anything happen to them. The strength of the battle will vary with every family depending on the

strength of the anorexia, your child's personality and characteristics, pre-existing mental health issues such as anxiety and OCD and any family dynamics that arise. The strength of your persistence needs to match the severity of the illness and your child will find your strength reassuring. Learn to be decisive against anorexia.

- Don't allow your pet dog to sit with your child while eating. Many pets have been fed the meal you thought your child had eaten.

- Make sure you display parental unity and are both on the same page regarding what your child needs to eat; that the meal is to be completed; that you will not negotiate with anorexia; and that you will back each other up. If anorexia sees any weakness in either parent, it will exploit it.

- Despite presenting difficulties, try to make meal times as normal as possible by engaging in family conversations and use distractions.

Remember

Be Confident
Be Consistent
Be Compassionate
Be Calm
Be Creative

Adapted from Ganci, Marcia (2016). Survive FBT. LMD Publishing; Melbourne, Australia

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

FAMILY SUPPORT GROUP

Family Support Group is held the second and fourth Wednesday of every month from 5:00PM to 6:00 PM in our office located at 919 Fremont Ave., Ste. 200, Los Altos, CA

Family support is an essential aspect of treatment. We understand that family involvement in your loved one's treatment is necessary, yet also challenging. The first group of the month is intended to be a safe and supportive place for loved ones to learn, connect, and offer support and valuable feedback to one another. The second group of the month is more structured, educational, and skills-based and will focus on a different recovery topic each month.

Due to the importance of family involvement, this group is a mandatory part of treatment. Please mark this date

THE HEALTHY TEEN PROJECT
A Place For Adolescent Eating Disorder Recovery

650.941.2300
erika@healthyteenproject.com