LifeStance HEALTH

Demographics Information Form

Please use this form to provide us your current demographic information.

Demographic Information

Title: ☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Dr ☐ Jr ☐ Sr ☐ Other: _____

First Name: _____

Middle Name: _____

Last Name: _____

Date of Birth: _____

Sex Assigned at Birth: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed
☐ Other: _____

Language: _____

Ethnicity: ☐ Decline to Specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
☐ Other: _____

Race: ☐ Decline to Specify ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other Race: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Preferred Phone: _____

Email: _____

Street Address: _____

_____

_____

LifeStance HEALTH

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____

LifeStance HEALTH

HIPAA NOTICE OF PRIVACY PRACTICES

EFFECTIVE AUGUST 1, 2021

Patient Name: _____
Patient DOB: _____

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.

Your health information is personal, and we are committed to protecting it.

LifeStance Health, Inc. ("LifeStance") provides management services to a number of entities engaged in the provision of behavioral healthcare services ("Behavioral Healthcare Entities"). All Behavioral Healthcare Entities are included in lifestance.com, a website maintained by LifeStance, and the behavioral healthcare clinic locations operated by Behavioral Healthcare Entities are provided at the following URL: https://lifestance.com/, as updated from time to time. LifeStance, its subsidiaries and the Behavioral Healthcare Entities are "affiliated covered entities" for purposes of HIPAA compliance and administration. As used in this Notice, the words "we," "our" and "us" collectively refer to LifeStance, its subsidiaries and the Behavioral Healthcare Entities. This Notice applies to LifeStance, its subsidiaries and all Behavioral Healthcare Entities, when acting as a covered entity and provides health care to you.

LifeStance uses and discloses health information about you for treatment, to obtain payment for treatment, and for administrative purposes, to evaluate the quality of care you receive, and for other purposes permitted by HIPAA. We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information and provide you notice of our legal duties and privacy practices with respect to your protected health information and to provide you with notice of a breach of your unsecured protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services or payment of healthcare services.

This Notice applies to all records involving your care that are created, and/or maintained by LifeStance. Your protected health information is contained in a medical record that is the physical property of LifeStance. LifeStance is required to abide by the terms of this Notice.

This Notice was published and became effective on August 1, 2021. We reserve the right to change our privacy practices, as reflected by this Notice, to revise this Notice, and to make the provisions effective for all protected health information it maintains. Revised Notices will be available on our website, in our clinics, or upon your request.

If you are a patient insured by the United States Department of Veteran Affairs, you may be entitled to rights and we may be subject to restrictions regarding the use and disclosure of your protected health information other than as set forth in this Notice. At all times, we will comply with the applicable requirements of the Department of Veteran Affairs regarding the use and disclosure of your protected health information.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION. Uses and Disclosures of Protected Health Information for Treatment, Payment, or Operations.

We may use or disclose your protected health information for treatment, payment and healthcare operations as described in this Section 1 without authorization from you. Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you. Your protected health information may also be used and disclosed to pay your healthcare bills and to support the operation of LifeStance.

Following are the types and examples of uses and disclosures of your protected healthcare information that LifeStance is permitted to make without your specific authorization. These descriptions and examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by LifeStance. In general, information regarding behavioral healthcare services we provide may be used and disclosed as provided below, but patients in some states may find that other types of protected health information are subject to additional rules under state law, as described in the table at the end of this Notice ("Addendum A").

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party, consultations with another provider, or your referral to another provider for your diagnosis and treatment. For example, a provider treating you may need to know if you have other health problems that might complicate your treatment and therefore may request your medical record from another healthcare provider that has provided treatment to you.

Payment: Your protected health information may be used to obtain or provide payment for your healthcare services, including disclosures to other entities. This may include certain activities that your health insurance plan may undertake before it approves or pays for the services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you, and undertaking utilization review activities. For example, we may need to give your insurance company information about therapy you received so your insurance will pay for the care.

Operations: We may use or disclose your protected health information in order to support the business activities of LifeStance. These activities include, but are not limited to: quality assessment and improvement activities; reviewing the competence or qualifications of professionals; securing stop-loss or excess of loss insurance; obtaining legal services or conducting compliance programs or auditing functions; business planning and development; business management and general administrative activities, such as compliance with the Health Insurance Portability and Accountability Act; resolution of internal grievances; due diligence in connection with the sale or transfer of assets of your provider's practice; creating de-identified health information; and conducting or arranging for other business activities. For example, we may use your health information to evaluate the

performance of our providers and staff in providing care to you. In addition, we may disclose your protected health information to another provider, health plan, or healthcare clearinghouse for limited operational purposes of the recipient, as long as the other entity has, or has had, a relationship with you. Such disclosures will be limited to certain purposes, including: quality assessment and improvement activities, population-based activities relating to improving health or reducing healthcare costs, case management, conducting training programs, accreditation, certification, licensing, credentialing activities, and healthcare fraud and abuse detection and compliance programs.

Business Associates: We may share your protected health information with a third party "business associates" that perform various activities (e.g., billing, transcription services, accounting services, legal services) for LifeStance. Whenever an arrangement between LifeStance and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Treatment Alternatives and Health-Related Products and Services: We may use or disclose your protected health information, as necessary, to provide you with information about a product or service to encourage you to purchase or use the product or services for the following limited purposes: (1) to describe our participation in a provider network or health plan network, or to describe if, and the extent to which, a product or service (or payment for such product or service) is provided by our practice or included in a plan of benefits; (2) for your treatment; or (3) for your case management or care coordination, or to direct or recommend alternative treatments, therapies, providers, or settings of care.

Communication: LifeStance may use and disclose your information to provide appointment reminders, leave a message, or leave a message with an individual who answers the phone at your residence.

Destruction of Records: LifeStance complies with state and federal regulations in regard to the destruction of records, specifically:

- The healthcare record of a person who is less than 23 years of age may not be destroyed;
- The healthcare record of a person must be maintained for 5 years, after it has been received or created, unless federal law requires that it be retained for a longer period of time; and
- The healthcare record of a person who has reached the age of 23 years may be destroyed after 5 years from the date the record was received or created, unless federal law requires that it be retained for a longer period of time.

Family and Friends: We may provide your protected health information to individuals, such as family and friends, who are involved in your care or who help pay for your care. We may do this if you tell us we can do so, or if you know we are sharing your protected health information with these people and you do not object. There may also be circumstances when we can assume, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your information to your spouse if your spouse comes with you into the exam room. Also, if you are not able to approve or object to a disclosure, we may make disclosures to a particular individual (such as a family member or friend), that we feel are in your best interest and that relate to that person's involvement in your care or payment of your care. For example, we may make a professional judgment about your best interests that allow another person to pick up things, such as prescriptions and medical supplies.

2. OTHER PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.

We may use or disclose your protected health information without your permission in the following circumstances, subject to all applicable legal requirements and limitations:

As Required by Law: As required by federal, state, or local law.

Public Health Activities: To a public health authority for public health activities including the following: to prevent or control diseases, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: To a health oversight agency for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: In response to a subpoena or a court or administrative order, if you are involved in a lawsuit or a dispute, or in response to a court order, subpoena, warrant, summons or similar process, if asked to do so by law enforcement.

Law Enforcement: To law enforcement for law enforcement purposes, so long as applicable legal requirements are met.

Coroners, Medical Examiners and Funeral Directors: To a coroner or medical examiner, (as necessary, for example, to identify a deceased person or determine the cause of death) or to a funeral director, as necessary to allow him/her to carry out his/her activities.

Organ and Tissue Donation: If you are an organ or tissue donor, to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate a donation and transplantation.

Research: For research purposes under certain limited circumstances. Research projects are subject to a special approval process. Therefore, we will not use or disclose your protected health information for research purposes until the particular research project has been approved through this special approval process.

Serious Treat to Health or Safety; Disaster Relief: To appropriate individual(s)/organization(s) when necessary (i) to prevent a serious threat to your health and safety or that of the public or another person, or (ii) to identify, locate, or notify your family members or persons responsible for you in a disaster relief effort.

Military and Veterans: As required by military command or other government authority for information about a member of the domestic or foreign armed forces, if you are a member of the armed forces.

National Security; Intelligence Activities; Protective Service: To federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related

to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.

Workers' Compensation: For workers' compensation or similar work-related injury programs, to the extent required by law.

Inmates: To a correctional institution (if you are an inmate) or a law enforcement official (if you are in that official's custody) as necessary (i) for the institution to provide you with health care; (ii) to protect your or others' health and safety; or (iii) for the safety and security of the correctional institution.

3. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION.

While we may use or disclose your health information without your written authorization as explained above, there are other instances where we will obtain your written authorization. Except as otherwise provided in this Notice, we will not use or disclose your protected health information without your written authorization. You may revoke an authorization at any time, except to the extent LifeStance has already relied on the authorization and taken actions.

Specific, examples, of uses or disclosures that require written authorization include:

- Marketing activities (unless an exception applies);
- Disclosures that constitute the sale of your protected health information;
- Disclosures of substance use disorder records (unless an exception applies);
- Most uses and disclosures of psychotherapy notes.

Federal and state laws may require authorization from you before we can disclose specifically protected health information. Examples of protected health information that may be subject to special protections include protected health information involving mental health, HIV/AIDS, reproductive health, sexually transmitted or other communicable diseases, and alcohol or drug abuse. We may limit disclosure of the specially protected health information to what the law permits or we may contact you for the necessary authorization. We have attached Addendum A to this Notice that identifies certain states, in which we provide healthcare services or have business operations, that may have more stringent privacy laws.

4. NOTICE REGARDING CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS (42 CFR §2.22).

The confidentiality of substance use disorder patient records maintained by certain LifeStance clinics is protected by federal laws and regulations (42 U.S.C. §290dd-2. 42 CFR Part 2). Generally, we may not tell a person outside of LifeStance that you are receiving services from us for a substance use disorder, or disclose any information identifying you as a person that has or had a substance use disorder, unless:

- You consent in writing to the disclosure; or
- The disclosure is made to a qualified service organization with which LifeStance has a written agreement; or
- The disclosure is allowed by a court order; or

- The disclosure is made to medical personnel in a bona fide medical emergency or to qualified personnel for certain research, audit, or program evaluation.

Federal law and regulations also do not protect any information about:

- A crime you commit or threaten to commit at any LifeStance location or against any person who works for LifeStance.
- Suspected child abuse or neglect required by state law to be reported to appropriate state or local authorities.

Violation by LifeStance of the federal law and regulations is a crime.

- Suspected violations by an opioid treatment program may be reported to the Substance Use and Mental Health Services Administration (SAMHSA), Opioid Treatment Program Compliance Office by phone at 204-276-2700 or online at OTP-extranet@opioid.samhsa.gov.

5. YOUR RIGHTS.

You have the following rights regarding your health information. To exercise any of the rights below, please contact Privacy@lifestance.com or call 800-308-0994 to obtain the proper forms.

You have the right to:

- **Inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in your medical record, including medical and billing records and any other records that your provider and the practice use for making decisions about you. We may charge you for the cost of copying, mailing or associated supplies.

  Under federal law, however, you may not inspect or copy certain records, including: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.

- **Request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice.

  LifeStance is not required to agree to a restriction that you may request, unless you request to restrict the disclosure of your protected health information to a health plan for the purpose of carrying out payment or healthcare operations and the protected health information relates only to a healthcare item or service for which you have paid us in full out of your pocket (not through insurance), in which case we will accept such restriction request. If we agree to the

requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

- **Request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

- **Request an amendment to your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

- **Receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It also excludes disclosures we may have made to you, for a clinic directory, to family members or friends involved in your care, or for notification purposes, disclosures for which you have signed an authorization and certain other disclosures You have the right to receive specific information regarding these disclosures that occurred during the six years prior to the date of your request. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

- **Obtain a paper copy of this Notice upon request and in a timely manner.** You may obtain a paper copy of this Notice by contacting LifeStance's Privacy Office at Privacy@lifestance.com or 800-308-0994. The Notice is also available in your clinic and on our website.

6. COMPLAINTS.

You may complain to us or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Office at Privacy@lifestance.com. We will not retaliate against you for filing a complaint.

7. NON-RETALIATION.

LifeStance will not retaliate against you for requesting access to your medical records, Notice of Privacy Practices or any other HIPAA-related documents. Further, LifeStance will not retaliate against you for filing or making us aware of any HIPAA complaints or grievances.

Contact Information:

If you have any questions or complaints about his notice or our privacy practices, please contact:

LifeStance Health, Inc.

LifeStance HEALTH

Privacy Office
4800 N. Scottsdale Road
Scottsdale, AZ 85251
Phone: 800-308-0994
Email: Privacy@lifestance.com

I acknowledge that I have received a copy of LifeStance's HIPAA Notice of Privacy Practices

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____

ADDENDUM A

Unless we obtain your specific authorization, the following types of protected health information only in limited circumstances and to specific recipients:

	Applicable States
(a) HIV/AIDS diagnosis or treatment	GA, FL, MA, MO, NH, NY, TX, OH, PA, WA
(b) Alcohol/Drug Abuse	CA, GA, FL, MA, MO, NH, NY, OH, PA, TX, VA
(c) Communicable Disease (including STDs) diagnosis or treatment	MA, TX, WA
(d) Reproductive Health information such as pregnancy or use of birth control	CA, FL, NY, WA
(e) Genetic	FL, GA, MA, MO, NH, NY, TX
(f) Mental Health	CA, FL, GA, IN, MA, MO, NH, NY, OH, PA, TX, VA, WA

***Please note that the table above does not provide an exhaustive list and may be updated from time to time. Even if it is not indicated as such on the table above, if a State has "stricter" privacy laws and such laws are applicable to us, then we will comply with the "stricter" privacy laws.

LifeStance HEALTH

STATE-SPECIFIC ADDENDUM FOR WISCONSIN

Disclosure Statement

LifeStance's professional staff consists of Psychiatrists, Psychologists, Advanced Practice Nurses, Registered Nurses, Licensed Mental Health Counselors, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Licensed Social Workers. The credentials and affiliations of your specific provider are available under the "find a provider menu" here: https://www.familyinnovations.com/therapists/

Patient Rights

1. You are entitled to receive information about your diagnosis, your provider's methods of therapy, techniques used, expected duration of therapy, and the cost of treatment.
2. You can seek a second opinion from another licensed professional, refuse recommended treatment, withdraw consent for treatment or terminate therapy at any time.
3. You are entitled to an explanation of the risks and benefits of treatment and the potential consequences of any decision you may make to decline or stop treatment.
4. Sexual intimacy is not appropriate in the context of a professional relationship and, if it occurs, must be reported to applicable state regulators.

Appointment Cancellation

Regular attendance at scheduled appointments is a key component of successful counseling. If you cannot attend an appointment, you must cancel 48 hours/2 business days in advance to avoid being charged a cancellation fee. Please note that Saturdays, Sundays and national holidays are not considered business days and notice of cancellation provided on those days will be deemed received on the next business day. If we do not receive notice of cancellation sufficiently in advance of your appointment, you will be responsible for the cancellation fee. Our cancellation fees vary by provider and service. This policy will be applied in all circumstances unless prohibited by law or our agreement with your insurer.

Fees

LifeStance maintains a fee schedule for each provider identifying the price of various services. If you have insurance and are receiving service covered by your insurance, the fee schedule may not accurately reflect our agreement with your insurer, which may affect the amount you are responsible for.

Late Cancellation/No Show Appointment Fee

Service	Late Cancellation Fee* (less than 48 business hours)	No Show Appointment Fee*
Appointment (MD)	New - $115 Established - $105	New - $115 Established - $105
Appointment (NP)	New - $105 Established - $95	New - $105 Established - $95

Appointment (PHD)	New - $105 Established - $95	New - $105 Established - $95
Appointment (MS)	New - $90 Established - $80	New - $90 Established - $80
Testing Appointment	$200	$350
Group Therapy	New - $65 Established - $50	New - $75 Established - 60
TMS	$25	$50

Other Potential Fees

Service	Description	Fee ($)
Collateral Service (MD)	Participation in meeting or conference, letters, forms	$40 per 15 minutes
Collateral Service (NP)	Participation in meeting or conference, letters, forms	$30 per 15 minutes
Collateral Service (PHD)	Participation in meeting or conference, letters, forms	$30 per 15 minutes
Collateral Service (MS)	Participation in meeting or conference, letters, forms	$25 per 15 minutes
Legal Fees	Testimony, responding to subpoena, all other legal related work for client or third party	$300 per hour
Record Release	Medical records request	$6.50
Prescription Refills	Prescription refill outside of appointment	$25
Returned Check Fee	Checks returned/unpaid	$35

*The Company may update these charges from time to time in its sole discretion.

Please note, if psychological or neuropsychological evaluation testing or assessments are provided, you may incur charges and co-payments for dates of services different than the dates the evaluations were actually administered. For example, charges related to scoring and interpreting test or assessment results, integrating other sources of data, and report writing.

Professional Relationship

To maintain an appropriately professional and therapeutic relationship, LifeStance providers will not socialize or spend time with clients outside of treatment. This also helps to maintain confidentiality for clients regarding their treatment relationship. Mutually respectful engagement is critical to a successful therapeutic relationship. Treatment can be uncomfortable and sometimes can create misunderstandings that lead to hurt feelings. If you have concerns about how your provider is treating you, please raise them and the provider or other LifeStance personnel will address them directly. Similarly, LifeStance does not tolerate rude, disrespectful, threatening or violent behavior. If your behavior causes our staff or professionals concern, we will remind you of our behavior standards.

Excessive or repeated violations of these standards may result in transfer or discontinuation of therapy in accordance with applicable legal requirements.

Testing and Assessment Services

Evaluation-only services, such as tests and assessments, are intended to help diagnose and guide treatment, but are not considered therapeutic treatment services themselves. The clinician conducting the evaluation is not available to provide treatment services, including emergency response or crisis intervention. Should your evaluation suggest the need for any therapeutic treatment services, your clinician will refer you to a provider as appropriate.

Privacy, Confidentiality and Records

Communications in the context of a therapist-patient relationship are generally confidential and record will be maintained in accordance with the strictest level of confidentiality applicable under federal or state law. This means that your provider generally cannot be required to disclose information about you or your care without your consent. Nonetheless, these laws provide numerous exceptions to confidentiality of information where information may be disclosed. Some of the most common situations where this can occur include the following:

- The patient signs a Release of Information permitting disclosure to a specific person, organization or group of persons;
- A professional determines that a patient poses a significant and immediate threat of harm to themselves, another identifiable person, or national security;
- A judge issues a court order requiring the disclosure of client records;
- A professional suspects that child or elder abuse or neglect has occurred;
- Criminal or delinquency proceedings where assessment or therapy is ordered by the court;
- You are determined to be gravely disabled due to a mental disorder.

In addition, it may be necessary to share information or records with other providers as part of your treatment or if you transfer your care.

Specific additional exceptions to the rule of confidentiality can be found at Wis. Adm. Code Psy 5.01(12), W.S.A. 51.30 and W.S.A. 146.82.

Records of your sessions, communications with and other documentation regarding your relationship with your treating provider will be maintained during treatment and after for the time period required by law. Records for couples seeking counseling as a couple will be maintained in a single record under the name of the financially responsible member. In the event that the financially responsible member is also, separately, a client receiving treatment as an individual, the record will be segregated and the other member of the couple will be able to access only the records from joint sessions.

Emergency Services

LifeStance does not provide emergency services. If you find yourself or a family member in a life-threatening situation, call 911 or go to an emergency room (at your cost).

If you are in a crisis, you can call the National Suicide Prevention Lifeline 24 hours a day, 7 days a week, at 800-273-8255.

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____

LifeStance HEALTH

AUTHORIZATION TO BILL CREDIT CARD ON FILE

Patient Name: _____

Cardholder Name: _____

Last Four Digits of Card Number: _____

By signing this form, I authorize LifeStance Health to charge the credit/debit card provided (the "Card") for all outstanding balances, including but not limited to, co-payment and co-insurance amounts, self-pay fee schedule amounts, no-show/cancellation fees, other administrative fees, and any balance remaining after insurance reimbursement relating to services provided to the patient. I understand that it is my responsibility to ensure that the information for the Card on file is current at the time of service, as necessary, and that if payment is declined, LifeStance Health may decline to provide new services until payment is received. I certify that I am an authorized signer for the Card with all necessary rights to authorize the charges.

Date: _____

Signature: _____

LifeStance HEALTH

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

Patient Name: _____

Patient DOB: _____

Provider: _____

INFORMATION TO BE EXCHANGED WITH:

I authorize LifeStance Health, Inc., and it's affiliate, (collectively "Provider") to share Protected Health Information ("PHI") about the Patient identified above with the following recipient:

Name: _____

Organization: _____

Address: _____

Suite Number: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Fax Number (optional): _____

I understand that "share" means to disclose orally in conversation, in writing or via electronic transmission. This authorization permits Provider to share information requested regarding my behavioral health treatment or the following types of information about the Patient (check all that apply):

- ☐ Evaluations
- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Mental Health Record Summary
- ☐ Medical/Hospital Records
- ☐ Psychological/Medical Test Results
- ☐ Discharge Summary
- ☐ Other: _____

- ☐ HIV/AIDS Diagnosis or Treatment Infection
- ☐ Sexually Transmitted Disease Diagnosis or Treatment Information
- ☐ Genetic Screening Test Results
- ☐ Substance Abuse Treatment or Diagnosis

LifeStance HEALTH

The purpose for sharing this information: _____

I understand that only the individual who has consented for care (including minors as required or permitted by state law) can authorize the release of PHI. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment. I understand that I can revoke this authorization at any time by sending a message via the patient portal or by writing:

LifeStance Health

If I cancel this authorization, I understand that cancellation will not apply to the extent that LifeStance has already relied upon my consent prior to receiving my written revocation. I understand that once the information has been released according to the terms of this authorization, that the information cannot be recalled, including after any revocation of this authorization. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules. Unless I revoke it earlier this authorization will expire one year after the date of my last visit with Provider or one year after the date I terminate my patient-provider relationship with LifeStance providers, whichever occurs later in time. Further, I understand that a copy of this document may be faxed or mailed to the above Recipient(s).

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____

LifeStance HEALTH

Congratulations on taking the first step toward improving your mental health. We know that sometimes the most difficult part of getting help is booking that first appointment. We're honored to help you!

To be serve you, we need you to fill out the forms below before your appointment. As you read them, you'll notice references to our company as "LifeStance" or "LifeStance Health." Please note Family Innovations, Inc., is proud to be a part of the LifeStance Health Family.

Thank you for completing these forms prior to your appointment. If you have any questions about our company, the forms below, or anything else, please feel free to contact us.

PATIENT SERVICES AGREEMENT

Patient Name: _____

Patient DOB: _____

A. INFORMED CONSENT TO TREATMENT

1. Outpatient Therapy. I give LifeStance[1] and the professional staff associated with or employed by LifeStance permission to perform all necessary care to treat me through outpatient therapy including counseling, psychotherapy, psychological assessment and/or psychiatric care. I understand that outpatient therapy has both benefits and risks. Risks may include the experiencing of uncomfortable or distressing feelings such as anger, frustration, anxiety, sadness, fear, guilt or helplessness because coming to therapy often requires discussion of unpleasant traumatic aspects of life. However, therapy also has many benefits if I am willing to put forth the effort required, maintain an open and motivated approach to sessions, and am willing to engage in conversation with my providers if I believe an aspect of services need to change. These benefits include, but are not limited to, increased insight and understanding of current challenges, increase in positive experiences and relationships, increased ability to cope and manage negative emotions and situations, and problem acceptance and resolution. Still, there are no guarantees about what will happen and additional referrals to better address the presenting challenges may be warranted.

2. Minor Patients. If the patient is a minor unable to consent to treatment independently, I, as the parent or legal guardian, understand that outpatient therapy may include the experiencing of uncomfortable or distressing feelings for my child/adolescent but also for me as the parent/guardian, and potential increase in behavioral issues as difficult issues are processed and strategies to modify the behaviors are implemented. I understand there is a risk of disagreement between parent or parents and the therapist regarding treatment. LifeStance will work to resolve these differences in the interest of my child/adolescent's therapeutic progress. However, parents/guardians ultimately decide whether services will continue. Additional details regarding the child/adolescent are set forth in the Minor Patient Addendum, which must be completed prior to the first service appointment. A minor able to consent to treatment independently will be deemed to have done so unless a Minor Patient Addendum has been completed by the adolescent's parent or guardian.

3. Couples Therapy. If I am participating in couples outpatient therapy, I understand that couples therapy may include the experiencing of negative emotions such as anger, frustration, anxiety, sadness, fear, or guilt because coming to therapy often requires discussion of unpleasant or traumatic aspects of my life or our relationship. I understand that it is possible that the relationship may seem to get worse before it gets better as each partner experiences personal change. Additional referrals to better address the presenting challenges may be warranted and could include referral to individual therapy.

4. COVID-19 and In-Person Services. I understand that by coming to the office, I am assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if I travel by public transportation, cab, or ridesharing service. LifeStance has taken steps to reduce the risk of spreading the virus within the office, and LifeStance has posted our efforts on our website and in the office.

5. Telehealth Services. I understand that LifeStance providers may provide me with services via telehealth modalities, and I authorize my LifeStance providers to do so at times in lieu of interacting with me in-person during a traditional practitioner-patient office visit, when such is permitted by state and federal law. I also understand that telehealth is the delivery of healthcare services using technology when the healthcare provider and the patient are not in the same physical location. I understand that there are risks and benefits associated with telehealth services and that there are circumstances and conditions specific to telehealth services, as follows:

i. *Potential Benefits of Telehealth Services*. My provider may choose to deliver services via telehealth because there are potential benefits associated with telehealth services as follows:

a. A patient is able to remain at a remote site while the healthcare provider receives information and provides healthcare advice at a different site.

b. The telehealth encounter may result in more efficient, timely and cost-effective healthcare evaluation and management.

c. The telehealth encounter may allow the provider or patient to obtain the expertise of a distance specialist that would otherwise not be available if a traditional in-person interaction was required.

ii. *Potential Risks of Telehealth Services*. As with any healthcare procedure or service, there are potential risks associated with the use of telehealth services, which include, but may not be limited to, the following:

a. Telehealth-based services and care may not be as complete as face-to-face services for certain patient needs and circumstances.

b. If my LifeStance provider believes that I would be better served by another form of services (e.g., in-person services), I may be referred to other providers who may provide such services.

c. In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate healthcare decision making by the practitioner.

d. Delays in healthcare evaluation and treatment could occur due to deficiencies or failures of the equipment.

e. In very rare instances, security protocols could fail, causing a breach of privacy of personal protected health information.

f. In rare cases, a lack of access to complete healthcare records may result in adverse drug interactions or allergic reactions or other judgment errors.

iii. ***Circumstances and Conditions Specific to Telehealth Encounter*****.** I understand and acknowledge the following circumstances and conditions specific to telehealth delivery of healthcare services.

a. in the event of any adverse or unexpected reaction to treatment, or inability to communicate as a result of technology or equipment failure, that may occur during or after my telehealth encounter, I should follow up with my primary care physician or emergency room for any urgent issues. I may contact LifeStance for any nonurgent issues. Telephone calls will be returned within 72 hours.

b. There are potential risks to this technology including interruptions, unauthorized access and technical difficulties, and that I may not hold LifeStance or my healthcare provider liable for technology failures.

c. My healthcare provider or I may unilaterally choose to discontinue the telehealth encounter if it is determined that the technology is not appropriate under the circumstances.

d. I have the right to withhold or withdraw my consent to the use of telehealth and/or telehealth services in the course of my care at any time, without affecting my right to be referred for future care or treatment from a qualified provider who provides in-person care.

e. A variety of alternative methods of healthcare may be available to me from other healthcare providers, such as an in-person encounter in lieu of a telehealth encounter, and that I may choose one or more of those options at any time from a provider who may, or may not, be affiliated with LifeStance.

f. Telehealth may involve electronic communication of my personal healthcare information to other healthcare practitioners who may be located in other areas, including out of state or internationally, when appropriate for providing me with care that I request.

g. All existing confidentiality protections apply to telehealth encounters, and I have the right to access all healthcare information related to telehealth encounters and to receive copies of such information at cost upon request.

h. There will be no further dissemination of any of my protected health information to other entities without my further written consent, or as otherwise permitted by law.

i. People other than my healthcare provider may be present in order to facilitate telehealth consultation, and I will be informed of their presence.

j. I have the right to any healthcare records created as a result of a telehealth encounter and all records will be maintained in a manner that is in compliance with state and federal patient privacy laws.

k. My telehealth encounter will not be recorded without my express consent.

l. When using technology to facilitate healthcare delivery, there may be cultural or language differences that may affect the delivery of services and there may be time zone differences between me and my healthcare provider(s).

m. There is the possibility of the denial of insurance benefits for telehealth encounters.

n. I will be provided with information regarding my healthcare provider(s)' training, credentials, license number, physical location, and contact information.

o. I will be provided with LifeStance's social media policy, encrypting policy, and policies on the collection, documentation, tracking, and storage of my personal information.

p. It is my duty to inform my healthcare provider of electronic or in-person interactions regarding my care that I may have with other healthcare providers.

q. I may expect the anticipated benefits from the use of telehealth services in my care, but no results can be guaranteed or assured.

r. I will have the opportunity to ask my healthcare provider any questions I may have regarding this consent before proceeding with a telehealth encounter.

6. Medication Data. I understand that information regarding medications currently in use can assist providers in tailoring therapy to be more effective and also to assist in avoiding side effects or adverse reactions due to conflicting prescriptions. As an exercise of my individual right of access, I authorize my provider to access and import into LifeStance's electronic patient record, all available information regarding drugs dispensed to me at any time in the past (collectively, "Dispensed Drug History"), regardless of source or circumstance. I understand that LifeStance will incorporate my Dispensed Drug History into its legal patient record and will only use or disclose my Dispensed Drug History as described in its Notice of Privacy Practices or as permitted or required by applicable law.

7. State Addendum. I acknowledge that I have accessed and reviewed the state-specific addendum applicable to the LifeStance Behavioral Health Entity providing my care.

LifeStance HEALTH

8. **Text/Email Communication.** LifeStance understands that we live our lives in email and text and that these might be the most convenient ways for us to communicate with you about our services, your health and your appointments. LifeStance also understands that the information you share with us is sensitive and we take the privacy and security of your personal health information very seriously. We want to strike the right balance for you. We will send you emails and texts regarding our services, your appointments, and products we may offer unless you tell us not to do so. Please note that sending this information over unencrypted email creates the potential for unauthorized parties to intercept your information. Similarly, if someone else has access to your email account, they may see this information. These kinds of unauthorized access can allow someone to know you are receiving behavioral health care and, in extreme cases, with other information that may be available about you from other sources, leading to medical identity theft. If you are not comfortable accepting these risks, please check the box below and sign this form.

☐ I do not want to receive communications from LifeStance via text and email.

Date: _____

Signature: _____

Name of Patient Representative, if applicable: [textbox]

Description of Patient Representative's Relationship to Patient, if applicable: [textbox]

[1] "LifeStance" includes LifeStance Health, LLC, and the Behavioral Healthcare Entities that LifeStance Health, LLC, manages. The Behavioral Healthcare Entities that LifeStance Health, LLC, manages are provided at the following URL: https://lifestance.com/, as updated from time to time.

B. FEES, THIRD-PARTY PAYORS AND SELF-PAY TIERS

I agree to pay LifeStance[2] for all charges incurred for services LifeStance renders to me, and I assign to LifeStance any monies due and owing under my health insurance plan or other third-party payor, including government payors, workers' compensation payors, personal injury case defendants and medical benefits accident insurance payors ("Med Pay"). I understand and agree that:

1. Primary Payment Responsibility. All LifeStance invoices for services and costs are due upon receipt, and all copay, coinsurance, and deductible amounts are due at the time service is delivered. LifeStance accepts credit and debit card (collectively "credit card") payments. I understand that LifeStance uses a third-party service that facilitates in-person and online payment transactions, and that LifeStance will not directly keep my credit card information on file. I grant LifeStance the right to automatically charge my credit card on file in each of the circumstances specifically identified in this agreement through the third-party service that LifeStance uses to facilitate credit card transactions.

2. Missed Appointments. A minimum of two business day notice is required for cancelled and missed appointments. If this notice is not received or if the patient fails to show for the appointment within the first 15 minutes of the scheduled appointment, I agree to be personally responsible for payment for the full amount for the time reserved for the appointment. I grant LifeStance the right to charge my credit card on file for the full reserved appointment time. I understand that health insurance does not pay for missed appointments. If unforeseen situations arise, such as illness, bereavement, and accidents, etc., I will provide documentation that will support my missed visit to avoid being invoiced for the full amount.

3. Third-Party Payors, Generally. I am responsible for all monies due and owing for services rendered by LifeStance in the event that any third-party payor does not pay for these services. It is ultimately my responsibility to ensure that any third-party payor covers, and makes timely payment for, LifeStance's services. In the event that any monies received for LifeStance from a third-party payor which the payor later recoups from LifeStance any time after their receipt, I will be responsible for those monies then due and owing. I grant LifeStance the right to charge my credit card on file for all requested services or tests: (i) at the time of service delivery; (ii) upon notice from a third-party payor that any full or partial charges are not covered by the third-party payor and/or (iii) if any previously paid amounts are recouped by the third-party payor.

4. Self-Pay Only with Health Insurance Coverage. If I have health insurance coverage that may cover some or all of the services provided by LifeStance, but I choose to self-pay and not use insurance to cover any LifeStance services, I understand that I will be fully responsible for payment of all services at the time of service delivery. I grant LifeStance the right to charge my credit card on file for all requested services or tests. By choosing this self-pay only option, I agree to not submit claims for LifeStance services to my health plan for reimbursement, and that any payments I make to LifeStance will not be credited toward satisfying any deductible or cost-sharing obligations I may have under my health insurance plan.

5. Self-Pay Combined with In-Network Health Insurance Coverage. I understand that if my LifeStance provider is an in-network provider for my health insurance plan, LifeStance may not bill me directly for any services that are otherwise covered under my health insurance plan. I certify that I have verified that any self-pay services I request of my LifeStance provider are not covered services under my health plan. For any services or tests that are not covered by my health insurance plan I

grant LifeStance the right to charge my credit card on file for all requested services or tests at the time of service delivery or upon insurance denial of coverage. For cost sharing, the right to charge my credit card on file for all requested services or tests at the time of service delivery or upon notice from the health insurance company that any LifeStance charges are the patient's responsibility.

6. Self-Pay and Government Payors. I understand that most LifeStance providers are participating providers for government-sponsored health insurance plans and that LifeStance may not bill me directly for any services that are otherwise covered for me by government payors. I certify that I have verified that any self-pay services I request of my LifeStance provider are not covered services under any government-sponsored health plans under which I am a covered participant. I grant LifeStance the right to charge my credit card on file for all requested services or tests at the time of service delivery or upon notice from the government payor that any LifeStance charges are the patient's responsibility or that are not covered services.

7. Self-Pay and No Health Insurance. If I do not have health insurance or qualify for government payor benefits for LifeStance services, I understand that I will be fully responsible for payment of all services at the time of service delivery, and I grant LifeStance the right to charge my credit card on file for all requested services or tests.

8. Off-Label Treatments and Tests, Generally. Many clinically appropriate medications, assessments or treatments are not currently FDA-approved or are considered experimental by third party payors and may not be reimbursable from third-party sources. I grant LifeStance the right to charge my credit card on file for all requested off-label treatment or tests not covered by third-party payors at the time of service delivery or upon notice of denial of payment by a third-party payor.

9. Full Coverage for Testing and Assessments. Coverage and cost for psychological and psychiatric assessments and tests vary across different third-party payors, and I am responsible for costs associated with the costs for the tests regardless of whether the costs are reimbursable by third-party payors on my behalf. This is because not all psychological testing services are guaranteed to be covered by third-party payors. At times, third-party payors do not fully reimburse psychological testing services, regardless of whether your clinician is an in-network or out-of-network provider. There are a variety of situations when this occurs; for example, when: (a) the third-party payor does not consider psychological testing "medically necessary" for "experimental" or "investigational" diagnoses; or (b) when the third-party payor reimburses fewer hours than billed by LifeStance based on what the LifeStance provider has determined to be clinically appropriate or necessary to administer the tests, scoring the tests, preparing the test report, and discussion of the results with the patient and/or attorneys. I understand that I will be fully responsible for payment of all services upon service delivery or upon notice of denial of payment by a third-party payor. I grant LifeStance the right to charge my credit card on file for all requested services or tests not covered by third-party payors at the time of service delivery or upon notice of denial of payment by a third-party payor.

10. Collections. In the event my account is turned over to an attorney or agency for collection, I agree to pay all costs of collection including, but not limited to, court costs and collection fees. If my account is not paid when due, a service fee and/or interest will accrue as permitted by law.

11. Other Insurance or Litigation Payor Sources. With respect to any administrative cases or personal injury cases, I am responsible for fees incurred when due regardless of the outcome of

pending litigation. The fees incurred will be in accordance with LifeStance's standard fees for court testimony, depositions and other litigation support as itemized in LifeStance's then-current chargemaster. I grant LifeStance the right to charge my credit card on file for all requested services, fees or tests at the time of service delivery. If there is any remaining balance(s) due at the time of case settlement, I authorize and will require my attorney to pay my outstanding accounts with LifeStance in first priority for payment from the settlement proceeds. LifeStance does not accept contingency fee arrangements.

12. Med Pay Coverage. In the event that I have Med Pay coverage, I permit LifeStance to classify and treat the Med Pay payor as the primary insurer over any other third-party payors. I irrevocably agree to a waiver permitting payment of Med Pay funds directly to LifeStance first in priority over me personally and any other potential claimant to the funds.

13. Forensic and Medical-Legal Requests. If applicable, forensic and medical-legal requests, conferences and telephone calls involve additional time and record-keeping for LifeStance, and I am responsible for all direct costs and expenses associated with LifeStance, and its attorneys and agents, in responding to discovery requests (including depositions and subpoena duces tecum time and labor costs) and with conferences including, but not limited to, court appearances, preparation of reports, photocopying, faxes, long-distance telephone calls, out of office travel, overnight delivery and courier services. I grant LifeStance the right to charge my credit card on file for all such requested forensic and medical-legal services and documentation time.

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____

[2] "LifeStance" includes LifeStance Health, LLC, and the Behavioral Healthcare Entities that LifeStance Health, LLC, manages. The Behavioral Healthcare Entities that LifeStance Health, LLC, manages are provided at the following URL: https://lifestance.com/, as updated from time to time.

LifeStance HEALTH

Adult Questionnaire

PRESENTING PROBLEM – Please briefly describe your concern(s)

CURRENT MEDICATIONS	PAST PSYCHIATRIC MEDS	ALLERGIES

MENTAL HEALTH HISTORY

Have you had past or current outpatient mental health treatment? ☐ Yes ☐ No
If yes, please specify, include provider and dates of treatment below:

Type	Provider/Date
☐ Therapy	
☐ Med Management	
☐ Psychological Testing	
☐ Hospitalization for Behavioral Health Reasons	

Additional Behavioral Health Information History

Please provider additional information regarding hospitalizations and medications:

Gender Identity:	☐ Male ☐ Female ☐ Trans Male/Trans Man ☐ Trans Female/Trans Woman ☐ Genderqueer/Gender Nonconforming ☐ Different Identity (please specify):
Sex Assigned at Birth:	☐ Male ☐ Female
Sexual Orientation:	☐ Heterosexual or Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Not Listed Above (please specify):

Relationship Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Partner

Current Living Situation:

Who is living in the home and their relationship to the patient:

Cultural/Ethnic/Spiritual Considerations/Identities:	Personal Strengths:

☐ Unknown Family History/Adopted

Do you or a family member have a history or prior diagnosis of:

	You	Family Members:
ADD/ADHD	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Anxiety	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Bipolar Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Depression	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Eating Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Encopresis/Enuresis	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Hallucinations/Delusions/Paranoia	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
OCD	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Panic Attacks	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Personality Disorder	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
PTSD/Trauma	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Substance Abuse/Dependences	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Other:	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather

Additional History:

MEDICAL HISTORY	
Primary Care Physician: ☐ Yes ☐ No	Name/Phone #:
Date of Last Physician Exam:	
Date of Last Dental Exam:	

Date of Last Vision Exam:	
Additional Healthcare Providers: ☐ Yes ☐ No	If yes, include name and phone numbers:

Do you or a family member have a history or prior diagnosis of:		
	You	**Family Members:**
Asthma	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Brain Trauma	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Cancer	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Diabetes	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Heart Disease	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
High Blood Pressure	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Kidney Disease	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Liver Disease	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Seizures	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Stroke	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Thyroid Problems	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather
Other:	☐	☐ Mother ☐ Father ☐ Child ☐ Sibling ☐ Grandmother ☐ Grandfather

Additional Past Medical History:

SUBSTANCE/ALCOHOL USE HISTORY
Alcohol Use:
Do you drink alcohol? ☐ Yes ☐ No Number of Times per Week: _____ Number of Drinks: _____

Smoking History:

Smoking Status: ☐ Nonsmoker ☐ Ex-smoker ☐ Cigar smoker ☐ Chew tobacco ☐ Current everyday smoker ☐ Current heavy tobacco smoker ☐ Current light tobacco smoker ☐ Pipe smoker ☐ Snuff user

Usage per Day: _____ Number of Years: _____

Do you vape? ☐ Yes ☐ No

Others Smoking in the Home: ☐ Yes ☐ No

Caffeine Use

How many drinks containing caffeine do you have on a typical day? ☐ None ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7 or more drinks

FOOD AND EXERCISE HISTORY

How often do you exercise? ☐ None ☐ 1-2x/week ☐ 3-4x/week ☐ 5+x/week

Do you have any concerns about your eating or exercise habits? ☐ Yes ☐ No

If yes, please specify:

EDUCATIONAL HISTORY

Highest education completed: ☐ Less than grade 12, specific grade: _____ ☐ High School ☐ GED ☐ Trade/Technical School ☐ Some College ☐ Undergraduate Degree ☐ Graduate Degree

Current Student: ☐ Yes ☐ No

If yes, please specify:

OCCUPATIONAL HISTORY

Occupational Status: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Unemployed

Occupation: _____ Length of Current Employment: _____

Employer: _____ How many positions have you held in the past 5 years? _____

Military Experience:

Military Experience: ☐ Current ☐ Previous ☐ None

Branch: ☐ Army ☐ Navy ☐ Marines ☐ Air Force ☐ Coast Guard ☐ Other: _____

If other, please describe:

Number of Deployments: _____ Years in Service _____ Discharge Status: ☐ Voluntary ☐ Involuntary

Thank you for taking the time to complete this questionnaire.

Completed by: _____ Date Completed: _____

Relationship to Patient: ☐ Self ☐ Patient ☐ Guardian ☐ Adult Child ☐ Other: _____