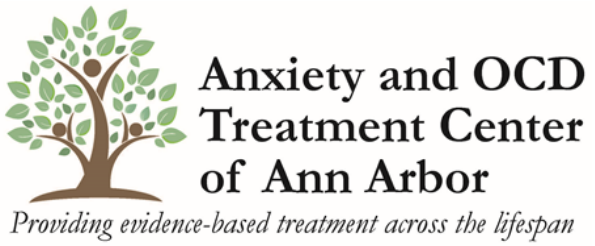

EVALUATION/ TREATMENT AGREEMENT

Welcome to the Anxiety and OCD Treatment Center of Ann Arbor. This document contains important information about our professional services and business policies. It is important that you read this document carefully and discuss any questions you have with your provider. When you sign this document, it will represent your informed consent for an evaluation and potential treatment and an agreement of policies.

Evaluation Overview

The therapy evaluation is a comprehensive set of in-person meetings with one of our clinicians, billed to insurance (if your plan is accepted by our providers) or paid out of pocket. This evaluation period will last one to three sessions depending upon the complexity of your individual situation. Each session is approximately one hour in length. We cannot determine the number of evaluation sessions required until after the first one-hour meeting has been completed. The purpose of the evaluation is to provide a thorough assessment of your potential anxiety and/or OCD symptoms. Our goal is to determine if treatment at our clinic will be helpful to you. Please note that we may determine at the evaluation that our clinic is not the best match for your therapy needs. We provide very specialized therapy, and not all presenting problems require - or benefit from - the therapy that we provide. In these cases, we provide recommendations for community providers who can deliver the evidence-based therapy that will best meet your needs. You may receive a list of our treatment recommendations after the evaluation is complete.

Evaluation Appointment: Wait Time

The wait time for an evaluation will vary depending on your schedule flexibility. **Please note that we only have daytime hours available for new clients.** Any prime time spots (4pm or later, weekends) are given to current clients that are being seen during the day while they wait for a primetime spot to be available. Initial_____

Evaluation vs Treatment

As noted above, we have an initial evaluation waiting list, and a separate treatment waiting list. If the evaluation determines that therapy at our clinic will be helpful for you, you may be added to our treatment wait list. We strive to make the wait between evaluation and treatment as short as possible, but your flexibility with appointment times will play the biggest part in determining the waiting time between evaluation and treatment.

Please note that while treatment recommendations will be provided at the end of the evaluation, no treatment is provided at the evaluation. Treatment will not begin until you are assigned an individual provider, assuming we recommend treatment at our clinic. As mentioned above, we may refer you outside our clinic if we believe that will best meet your needs.

By signing, you are agreeing to an evaluation at the Anxiety and OCD Treatment Center of Ann Arbor for yourself/your child. You understand that an evaluation is not a guarantee of treatment and that you may be given alternative recommendations for treatment if our clinical team determines our clinic is not the best fit for your/your child's needs. _____

Signature

Cancellation Policy

Due to the very high demand for our services and our extensive waiting list, we require 72 hours notice for cancellations for evaluation appointments. This gives our Office Manager sufficient time to schedule another person into the evaluation slot. Late canceling or not showing up to your evaluation appointment interferes with our ability to maximize our clinician's schedules and provide clinical care in the most efficient manner possible. **To minimize the scheduling and financial impact of late cancellations, we require payment of the full evaluation fee if the session is not canceled or rescheduled with at least 72 hours notice. The full evaluation fee for the initial evaluation session is currently $260 for fully licensed psychologists, $225 for social workers and limited licensed psychologists, and $175 for limited licensed social workers. For follow-up evaluation sessions, the late cancel/no show fee is $200 for fully licensed psychologists/ $175 for social workers and limited licensed psychologists/ $150 for limited licensed social workers for appointments before 3 pm on weekdays, and $235 for fully licensed psychologists/ $200 for social workers and limited licensed psychologists/$175 for limited licensed social workers for appointments after 4 pm on weekdays or anytime on weekends.** Insurance will not cover the missed appointment fee. We require a credit card be placed on file prior to the evaluation. If you have questions regarding this process, please contact our Office Manager. We thank you for your understanding.

Once accepted for treatment at our clinic, therapy appointments must be canceled with 24 hours notice. If an appointment is canceled with less than 24 hours advance notice, you will be charged according to the current fee schedule (see below). It is important to note that insurance companies do not provide reimbursement for canceled sessions.

Billing and Payments

Payment is due at the time of service. We require a credit/ debit/FSA card be on file for the payment of copays, deductibles, missed appointments, and other session fees. These fees will be processed post session automatically by our EHR system/office staff or by your provider. Fee processing can take up to two weeks depending on how long your insurance takes to process claims. Please refer to the Billing tab and Ledger in your patient portal for all claims and applied payments before contacting the clinic regarding billing questions. It is your responsibility to provide our office with

your insurance information, to let your provider/office staff know of any changes to your insurance or payment method on file or to update your insurance or payment method in your patient portal. Please let your provider know if you prefer to pay by cash or check, but note that a card will still be required to be on file in your account. Please be advised that while our clinic may provide an estimate of your insurance coverage, ultimately it is your responsibility to check with your insurance to see if they provide in-network coverage (or out of network reimbursement) prior to the evaluation session and to know what is covered by your HSA/FSA.

You will be expected to pay for each session at the time it is held. Late charges will be added to accounts with any balance over 30 days old. Late Fees are calculated at a rate of 2% monthly. If your account has not been paid for more than 90 days and you have not arranged payment, we have the option of using legal means to secure payment, including collection agencies or small claims. In most collection situations, the only information released regarding a client's treatment is their name, the nature of services provided, a copy of this agreement and the amount due. If such action is necessary, the cost of $24 incurred by our clinic will be included in the claim and charged to you.

"Friendly Fraud" Policy

"Friendly fraud" is a term defined as identifying a charge on your credit card as unauthorized by starting a chargeback request. This can result in excessive time spent on the part of our administrative staff in contesting these fraud claims, which can be extremely costly to businesses. We are fully aware that most patients are not realizing that asking for a refund for services rendered by stating an approved charge was unauthorized is technically a financial fraud. Please be aware that the first step to a chargeback process as defined by the Federal Fair Credit Billing Act (FCBA) is to contact the merchant and provide them with an opportunity to clarify any confusion. If you believe that your credit card has been charged erroneously, you must take the following steps before contacting your credit card company for a refund.

1) Login to your patient portal and review the financial summary/ledger under the Billing tab which will indicate what days charges were run and how each charge was applied for services.
2) Review the this initial treatment agreement form and billing practices that you signed in agreement, prior to participation in treatment with our clinic.
3) If you have any questions or concerns after reviewing the portal documentation, please send an email (phone calls are not sufficient due to the paper trial required under federal law) to frontdesk@anxietyannarbor.com stating you have a question or concern about billing.

If these steps are not followed prior to contacting your bank/credit card company about an unauthorized charge that is deemed as authorized by the card carrier and treatment forms provided at the start of treatment, you will be charged the fees we as merchants are charged for each false fraud claim of $30. Additionally if we are charged other fees by your bank/credit card company, you are also responsible for reimbursement for these fees. Please be aware under the FCBA, you are also

subject to potential banking fees, credit consequences and loss of access to services. Any instance of false fraud claims without taking these 3 steps first, will subject you to loss of ongoing treatment at our clinic.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. Most of our providers currently panel with BCBS and Blue Care Network. You are expected to contact your insurance company prior to service to determine your behavioral health benefits coverage. If at any point it is determined that your benefit doesn't pay for or pay fully for treatment you are responsible for the charges. **Please note, we are able to bill BCBS and BCN when they are the primary insurance.

None of our clinicians are able to accept Medicaid, Blue Cross Complete, Medicare Plus Blue, BCN Advantage or Healthy Blue Choices insurance.

Out of network services. We do not bill out of network. You will have access to an invoice in the patient portal that you can submit to your insurance company if you are seeking out-of-network reimbursement. We cannot guarantee successful out-of-network reimbursement and strongly encourage you to contact your insurance company prior to services to determine your out-of network benefits. Please note that we are not able to assist with obtaining out-of-network reimbursement beyond providing an invoice of the service received.

Flexible Spending. Proof of service receipts to submit to your flexible spending/health savings account for reimbursement can be found in the Billing Ledger in the patient portal. Instructions for locating the ledger statements can be obtained by contacting the front office. You may be able to use your flexible spending account for reimbursement of therapy or psychiatric services, however it is your responsibility to confirm eligibility of reimbursement for services provided by an LLMSW, with your specific health savings account.

Late Arrival Fees

This fee will be based on a prorated charge (i.e., a charge for the portion of the session that was missed, calculated based on the full scheduled session cost). For example, if our typical session is 60 minutes (90837) at a rate of $175 for an LMSW and you arrive 15 minutes late, we reserve the right to charge you for the ***difference*** of the scheduled session fee and the cost of the time you were in session ***in addition to*** the time you were present in session; $175 (90837, 60 minute session)-$150 (90834, 45 minute session held)=$25 late fee, in addition to $150 (45 minute session held). **If you are 10 minutes or more late for an evaluation session, you will likely be asked to reschedule and charged the full fee for the missed session.** Insurance will not pay for the late arrival fee. Insurance will be billed for time spent in session. You will still be responsible for the late arrival fee.

Because there may be insufficient time for treatment or due to insurance billing rules, your provider reserves the right to end the session if you are 15 or more minutes late to a scheduled 45 or 53 minute session or 10 or more minutes late to a scheduled 30 minute session. A full late cancellation fee may be charged.

Contacting Your Clinician

Our clinicians are often not immediately available due to the nature of their work. You can contact your provider through your patient portal, email, or by phone (direct or through the clinic number). Please leave a message for your clinician and they will make every effort to respond within 24 hours (with the exception of weekends and holidays). Should you decide to contact your clinician via email, please note that this is not a secure means of communication and you are accepting the risk associated with transmitting personal information over the internet. Emails should be limited to scheduling, as they are not a means by which our clinicians can provide appropriate clinical care. All provider emails can be found on our website, anxietyannarbor.com. If you cannot reach your clinician and feel that you have an emergency, call 911 or go to the nearest emergency room and ask for the psychiatrist on call. If your clinician will be unavailable for an extended period of time, you will be notified and provided with contact information for another clinician, if necessary.

Clinician Supervision

Our clinic provides training in evidence-based treatment to limited license clinicians. A limited license clinician is qualified by the State of Michigan to deliver assessment and treatment services under the supervision of a fully licensed provider. You will be notified of the name and contact information of the fully-licensed clinician within our Center who is supervising your clinician.

LLMSW INFORMATION

A LLMSW is defined as a Limited License Master of Social Work, which means they have completed their master's degree and are working toward obtaining the required 2,000 hours of supervised clinical work. All LLMSW cases will be reviewed in supervision with a fully licensed clinical social worker on a weekly basis at the Anxiety and OCD Treatment Center of Ann Arbor. All LLMSW clinicians at the Anxiety and OCD Treatment Center of Ann Arbor have received additional specialized training in evidence-based treatments for anxiety and OCD related disorders.

Observation and Recording

The treatment of anxiety disorders and OCD requires specialized evidence based methods. Unfortunately, there are not enough providers trained in these methods to meet the enormous demand of people in need of treatment. As part of our commitment to treating those dealing with anxiety disorders and OCD, we strive to train more clinicians in the specialized evidence-based techniques we use, thus allowing for more clinicians to be able to effectively provide treatment. One method of training we use is direct treatment observation. By allowing other clinicians to observe sessions, we are expanding on their training and contributing to the number of providers that will be able to go on to help other people.

Because we are a training clinic, your/your child's evaluation/treatment may be observed by other clinicians on staff at the Anxiety and OCD Treatment Center of Ann Arbor for training purposes. Those observing are bound to the same laws of confidentiality as your primary therapist.

As part of being a training clinic, your sessions may be video/audio recorded. The purpose of this recording is to help your provider serve you better and to review and evaluate their treatment techniques. This recording may also be used for training purposes for other clinicians at the Anxiety and OCD Treatment Center of Ann Arbor. No recording will be done without your prior knowledge and consent. No copies of any video/audio files will be made or shared in any way. Viewers of the video/audio file(s) will only include your provider and the other clinicians at the Anxiety and OCD Treatment Center of Ann Arbor. All viewers of the video/audio file(s) are bound by the ethical and licensing standards and all HIPPA privacy laws. The video/audio file(s) will be treated with confidentiality and stored in a locked secure location. Recordings will not become part of your clinical record and will be destroyed upon your completion of treatment.

_____ I understand that clinicians of The Anxiety and OCD Treatment Center of Ann Arbor may observe or video/audio record mental health sessions for purposes of education, training and/or quality of service evaluation. I understand that:

1. The observation and recording will only be by staff and/or interns for purposes of education, training and/or quality of service.
2. Consent to observation and recording is voluntary
3. The observation or video/audio recording may be done from within the room or over telemedicine

_____ I understand that I have the right to refuse to allow others to observe or record sessions at any time. I understand that:

1. If I do not want other clinicians to observe or record, I will inform my clinician prior to session or at any point during session.
2. Refusal to allow observation or recording has no impact on the provision of services

Client Rights

HIPAA provides you with several new or expanded rights concerning your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to view and copy your records. Your clinician will be happy to discuss any of these rights with you. These rights are explained further in the Privacy Notice. If you have a complaint,

we encourage you to attempt to resolve it with your clinician. If the resolution is unsatisfactory to you, you may contact the Washtenaw County Recipient Rights Office at (734) 544-3000 and ask to speak with the Rights Officer of the Day.

Confidentiality

In general, the law protects the privacy of all communication between a client and a behavioral health provider. In most situations, we only release information about your evaluation or treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. However, we must also release information without consent in the following situations:

- If a client presents an imminent danger to him/herself, we may be required to seek hospitalization for the client, or contact family members or others who can help provide protection.

- If there is cause to suspect a child under 18 is abused or neglected, or reasonable cause to believe that a disabled adult is in need of protective services, the law requires that a report be filed with the appropriate agency. Once such a report is filed, additional information may be required.

- If there is reason to believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, and/or calling the police.

- Parental involvement is essential to successful treatment and this may require that some private information be shared with parents. It is our policy only to share information that is considered necessary with a minor client's parents. This includes general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Before giving parents any information, this will be discussed with the child, if possible, and an attempt will be made to handle any objections he/she may have.

- Children over the age of fourteen have the right to independently consent to and receive mental health treatment without parental consent and, in that situation, information about that evaluation or treatment cannot be disclosed to anyone without the client's agreement.

Please be advised that our clinic does not control your information held by your insurance company once claims are billed to your insurance provider. It is important that any questions or concerns that you may have now or in the future be discussed immediately with your clinician or insurance carrier.

Exposure Therapy

Exposure therapy often takes us outside of the therapy office and into the "real world." Even in the therapy office we may be doing real world activities. We may encounter situations in which:

(1) confidentiality/privacy considerations arise (i.e., incidental disclosures according to HIPAA, such as overhearing conversations while social anxiety exposure is being conducted)

(2) potential liability may be a result of your voluntary participation in real world activities via exposure therapy.

Our attached "Release of Liability Waiver" reviews this in more detail. Your initials below indicate that you understand that:

- Your clinician(s) and the Clinic in general cannot ensure complete privacy/confidentiality during exposures.
- You (or your child) may observe other Clinic clients participating in exposures, and will respect their privacy and confidentiality (i.e., not discuss what you observe with others)
- Sometimes clinic staff and/or clinicians other than your primary provider are used as a part of an exposure in session (ie. exposure to having small talk or exposure to giving a speech in front of others). This is a necessary part of treatment and is different than "observation" described above. All clinic staff/clinicians are bound to the same rules of confidentiality.
- You (or your child) are participating in exposure therapy on a voluntary basis, and in no way mandated by the Clinic. You hereby release the Anxiety and OCD Treatment Center of Ann Arbor as well as its staff and clinicians from any claims, demands, and causes of action as a result of your (or your child's) voluntary participation and enrollment in treatment at our Clinic.

_____ I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE.

Minor Clients

(please initial the appropriate option for your child ******PLEASE READ ALL OF THE OPTIONS******)

____ _____ lives with BOTH legal/biological parents/guardians and
(child's name) there is **NOT** a legal custody agreement in place,

_____ I am the Sole Legal Parent/Guardian of _____ and there is **NOT** a
(child's name) custody agreement in place,

_____ I am the Sole Legal Parent/Guardian of _____ and there **IS**
(child's name) a custody agreement in place,

_____ I am the Joint Legal Parent/Guardian of _____ and there **IS**
(child's name) a custody agreement in place,

_____ I am the Joint Legal Parent/Guardian of _____ and there is **NOT**
(child's name) a custody agreement in place,

therefore I have the legal authority to enter this child into evaluation and therapy and to sign papers on the child's behalf. I understand that if there is joint legal custody with another person, that person may also be involved in the child's therapy and/or may receive communication from the therapist. I will provide the Anxiety and OCD Treatment Center of Ann Arbor a copy of any legal custody agreements in place regarding the client.

****

PROFESSIONAL FEE SCHEDULE*

Type of Service	**LMSW/LLP/TLLP**	**PhD/LP**	**LLMSW**
Initial Evaluation*	$225.00	$260.00	$175.00
90832 (16-37 minute session)	$90.00	$105.00	$75.00
90834 (38-52 minute session)	$150.00	$165.00	$130.00
90837 (53-60 minute session)	$175.00	$200.00	$150.00
90846 (family session w/o client)	$175.00	$200.00	$150.00
90847 (family session w/ client)	$175.00	$200.00	$150.00
90839 (60 minute crisis session)	$200.00	$235.00	$160.00
90840 (Additional 30 minutes for crisis session)	$150.00	$165.00	$130.00
Group session	$75.00	$75.00	$75.00
Intensive ERP per hour	$175.00	$200.00	$150.00
Other Fees			
Paperwork (per hour)	$175.00	$175.00	$175.00
Rush Fee (paperwork/letter needed w less than 48 hours notice)	$50.00	$50.00	$50.00
Communications**			
Phone/email (15 minutes or less)	$50.00	$50.00	$50.00
Phone/email (16-37 minutes)	$90.00	$105.00	$75.00
Phone/email (38-52 minutes)	$150.00	$165.00	$130.00
Phone/email (53-60 minutes)	$175.00	$200.00	$150.00
Form preparation per 15 minutes	$50.00	$50.00	$50.00
Travel Time (30 minute minimum plus 15 minute increments thereafter)	$90.00 $40 per add'l 15 min	$100.00 $45 per add'l 15 min	$80.00
PsyPact State Fee (virtual/LP)	$25 - 90791/$75- first 90837		
No shows, late cancellations:			
Weekday morning/afternoon	$175.00	$200.00	$150.00
Late Afternoon(4p+)/Evening/Weekend	$200.00	$235.00	$175.00
Returned Check/Bank Fee	$25	$25	$25
Collection Agency Fee	$24	$24	$24

*Initial evaluation can be 1-3 sessions. The first of session will be at the initial evaluation rate and subsequent sessions will be at the 90837 rate.
**Fees for phone calls not billable to insurance or for private pay clients. To be billable to insurance, phone calls must be initiated by the client, cannot be related to an illness/service the client received in last 7 days and cannot result in scheduling client for a session with in 24 hours.
***We reserve the right to alter and update the Fee Schedule at any time. Review of the fee schedule occurs at minimum on an annual basis. All clients will be notified in writing of changes in fees at least 4 weeks prior to implementation.*

By signing below I, _____, acknowledge that I
(Print) Client's Full Name or Parent/Guardian name if minor client
understand and accept all the terms in the above agreement for services provided by my clinician. I also acknowledge that I have received the HIPAA information (Notice of Privacy Practices) described above.

_____ _____
Client's Signature (required for clients 18 years or older) Date

_____ _____
Parent or Legal Guardian's Signature (required for minor clients 17 or younger) Date

Credit Card Consent

I, _____, do consent to allow my provider(s) with the Anxiety and OCD Treatment Center of Ann Arbor to store my credit/debit/FSA card information on file for myself and/or my child for the purpose of processing payments for services and/or fees incurred. I understand that such information will be stored in a secure manner, just as my (or my child's) medical record is stored securely.

Please note than an FSA or HSA card CANNOT be used for the purpose of a missed or late cancellation fee.

The credit/debit card information I would like my provider to use is as follows:

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Client's Name_____

Name on the Card_____

Card Number_____

Expiration Date_____ Billing Zip Code_____
CVV (last 3 digits on back of card for Visa, MC & Disc; four digits on front of card for Am Ex)_____

Is this an HSA/FSA card? ☐ Yes ☐ No

I understand the following:

- ◊ I will be charged after each session for the appropriate amount (e.g., copay, deductible, etc). My provider will notify me if the amount they regularly charge changes.
- ◊ If I miss a session, I will be charged per the Cancellation Policy detailed in the agreement above.
- ◊ I may revoke this consent at any time by providing sufficient written notice. I understand that my consent is not considered fully revoked until my provider confirms receipt of said notice.
- ◊ If my card information changes, I will update my provider. I am able to change my method of payment by contacting my provider, the front office or through my patient portal.
- ◊ If the card listed above is not the client's own card (i.e., in client's name), I consent to the Clinic contacting the card holder if needed to discuss billing matters, should billing issues arise. The card holder can be contacted via phone at _____.

My signature below indicates that I have reviewed all information in this Consent to Evaluation. My signature also indicates that I have reviewed the Clinic's cancellation policy information and agree to the Credit Card Charge consent terms.

_____ _____
Client name Client Signature Date

_____ _____
Parent/Guardian Name Parent/Guardian Signature Date

WAIVER AND RELEASE OF LIABILITY FOR THERAPY

In consideration of the risk of injury while participating in Exposure Therapy with an Associate of the Anxiety and OCD Treatment Center of Ann Arbor (the "Activity"), and as consideration for the right to participate in the Activity, I hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the Activity, and do hereby release and forever discharge The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center, located at 2610 W. Liberty, Ann Arbor, Michigan

48103, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Activity, including traveling to and from an event related to this Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH TRAVELING TO AND FROM AS WELL AS PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, PROPERTY LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE OR ACTIONS, CONDITIONS RELATED TO TRAVEL, THE CONDITION OF THE ACTIVITY LOCATION(S), OR OTHER FACTORS. NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN OR UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY, INCLUDING TRAVEL TO, FROM AND DURING THIS ACTIVITY.

I agree to indemnify and hold harmless The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center incurs any of these types of expenses, I agree to reimburse The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center as said expenses are incurred.

I acknowledge that The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center and their directors, officers, volunteers, representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I

AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center, its agents, and employees.

In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

This Agreement was entered into at arm's-length, without duress or coercion, and is to be interpreted as an agreement between two parties of equal bargaining strength. Both the Undersigned Participant and The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center agree that this Agreement is clear and unambiguous as to its terms, and that no other evidence will be used or admitted to alter or explain the terms of this Agreement, but that it will be interpreted based on the language in accordance with the purposes for which it is entered into.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

I, the undersigned participant, affirm that I am of the age of 18 years or older, and that I am freely signing this agreement. I certify that I have read this agreement, that I fully understand its content and that this release cannot be modified orally. I am aware that this is a release of liability and a contract and that I am signing it of my own free will.

Participant's Name: _____

Signature: _____Date: _____

PARENT / GUARDIAN WAIVER FOR MINORS

In the event that the participant is under the age of consent (18 years of age), then this release must be signed by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of the participant/client named above, and do hereby give my consent without reservation to the foregoing on behalf of this individual.

Parent / Guardian Name: _____Relationship to Minor: _____

Signature: _____Date:_____