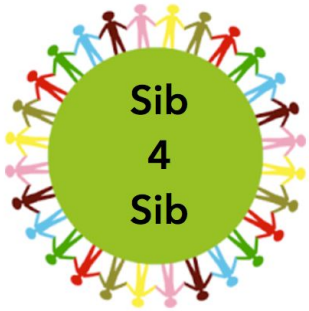
Group Forms for

Please return upon arrival at the first session



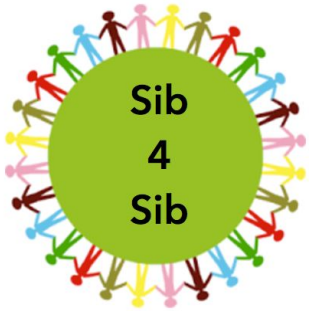
GROUP CONFIDENTIALITY AGREEMENT

By signing below, I agree to the following group guidelines regarding confidentiality.

1. All information shared within the group will remain confidential; no one will share anything discussed within session with anyone outside of the session.
2. If you do want to discuss something that came up for you during the group with someone outside the group, please ensure that you do not disclose anything shared by other individuals or mention anyone else's situation or name.
3. Out of respect for the others in the group, please do not mention to anyone else (including your family) who else is in the group with you. We want this to be a safe space for all.
4. No materials, notes or summaries, will be released without your written consent, except in the conditions outlined within the HIPPA agreement provided to you. If you have any questions about these limitations of confidentiality, please discuss them with the Facilitator – preferably prior to the start of the group.
5. If there is ever a concern about safety (whether yours or that of another) then confidentiality does not apply and the appropriate individuals will be contacted to ensure everyone's safety.

_____.

Participant Signature Date



Parents and/or Guardians,

Please know that if there is ever something shared within the group that raises a concern about safety, you or an emergency contact will be contacted immediately (please ensure that you've provided the emergency contact information on the participant information form). However, other than in situations where safety is an issue, or in the circumstances outlined on the HIPPA form provided to you, all other information discussed within group will be kept private. Accordingly, no information shared within the group is to be discussed outside of the group. This helps ensure a safe and supportive environment for all. Given this, we ask you to adhere to the following guidelines:

1. Please do not ask your child about anything discussed within the group sessions.
2. Know that if your child believes it will be beneficial to them, they will approach you to discuss things that resonated with them from the session. Please allow them to come to you and do not initiate any discussion around what they have been discussing within the group session.
3. If your child does approach you to discuss something from the group, please do not ask them (or allow them to) disclose other individuals' names.
4. Please do not ask your child who else is attending the group with them. Similarly, if you do see other individuals entering the group who you recognize, please do not mention this to them or engage in discussion about the group with their parents.
5. If at any point you are concerned about your child's safety or the safety of another, please call 9-1-1 or go to your nearest emergency room.

If you have any concerns about the points outlined in this agreement, please don't hesitate to reach out to the facilitator.

I have read and agree to the policies stated above for my child _____ (print name). I further provide my consent to have them participate in the Sib4Sib group.

_____.

Parent Signature (If minor, guardian signature required) Date

Parent Contract

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

If you have any questions about this Privacy Notice, please contact the facilitator. This Notice of Privacy Practices is being provided to you as a requirement for the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and give out "disclose" your health information to carry out treatment, payment or heath care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases.

Treatment: We may use and disclose health information about you for the purpose of coordinating your health care. For example, we may need to disclose information to a case manager at a managed care organization who is responsible for coordinating your care.

Payment: We may use and disclose health information about you so that the services you receive can be properly billed and paid. For example, we may disclose your health information to permit your health plan to take certain actions before your health plan approves or pays for your services.

Operations: We may use or disclose health information about you, as necessary, so that we can operate the health plan and provide quality care to you. For example, we may use health information about you to review the quality of services you receive.

Other Uses and Disclosures: As part of treatment, payment and health care operations, we may also use or disclose health information about you so that we can send you healthcare service reminders and/or newsletters.

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons. These reasons include the following:

• When Required by Law: We will disclose health information about you when we are required to do so by law.

• When There Are Risks to Public Health: For example, we may disclose your health information to prevent, control or report a disease.

• To Report Abuse, Neglect or Domestic Violence: We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence.

• To Conduct Health Oversight Activities: We may disclose your health information to a health oversight agency for activities such as audits or inspections.

• In Connection With Judicial and Administrative Proceedings: We may disclose your health information in the course of any judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a signed authorization (in a format approved by the Michigan Court Administrator).

• For Research Purposes: We may use or disclose your health information for research under limited circumstances.

• In the Event of A Serious Threat to Health or Safety: We may use or disclose your health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health or safety of the public.

• For Specified Government Functions: In certain circumstances, the Federal regulations authorize us to use or disclose your health information to facilitate specified government functions such as functions relating to national security.

• For Worker's Compensation: We may release your health information to comply with worker's compensation laws or similar programs.

Family Matters: Unless you object, or we can infer from the circumstances that you do not object, we may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care.

Authorization: Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

Your Right to Inspect and Copy: You may request the right to inspect and get copies of your health information. To inspect and copy your health information, you must submit a written request to the facilitator, whose contact information is listed on the first page of this Notice. We can deny your request for certain limited reasons, but we must give you a written reason for denial. We may charge a fee for copying your records.

Your Right to Request a Restriction on Uses and Disclosures of Your Protected Health Information: You may ask us not to use or disclose certain parts of your health information for the purposes of treatment, payment or health care operations. We are not required to agree to a restriction. You may request a restriction by contacting the facilitator.

Your Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests only if you notify us that disclosure of the health information could put you in danger. Requests must be made in writing to the facilitator. This written request must also contain a statement that disclosure of the information could endanger you.

Your Right to Amend: If you feel that the information we have about you is incorrect or incomplete, you may request that we amend your information. If we deny your request, we must give you a written reason for our denial. Requests must be made in writing to the facilitator. In this written request, you must also provide a reason to support the requested amendments.

Your Right to a List of Disclosures: You have the right to request a listing of certain disclosures of your

health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form and certain other disclosures that we are permitted to make without your authorization. The request for listing must be made in writing to the facilitator. We are not required to provide a listing of disclosures that took place prior to April 14th, 2003. We will provide the first listing that you request during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

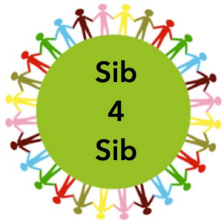
Your Right to a Copy of This Notice: You have the right to receive an additional copy of this Notice at any time. Even if you have already received a copy of the Notice or have agreed to accept this Notice electronically, you are still entitled to a paper copy of this Notice. Please call or write to the facilitator to request a copy.

How to Use Your Rights Under This Notice: For any of the above requests that must be made in writing, we will help you prepare the written request if you need assistance. For assistance with a written request and for oral requests, please call the facilitator

Our Duties: We are required by law to maintain the privacy of health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by the terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that we maintain. If we make any major changes to our Notice, you will receive a copy of our new Notice within 60 days of the major changes.

Complaints: If you believe your privacy rights have been violated, you have the right to complain to us. You may complain to us by contacting the facilitator verbally or in writing. We encourage you to express any concerns you may have regarding the privacy of your information to us. You will not be retaliated against in any way for filing a complaint.

Contact Person: The contact person for all issues regarding the privacy of your health information is the facilitator.



PARTICIPANT INFORMATION FORM

Name: _____ _____ _____

(first) (middle) (last)

Date of Birth (mm/dd/yyyy): _____

Address (including city, state, and Zip): _____

_____

Gender: _____ Grade: _____

Email Address (if desired): _____

Cell Phone: _____ No Messages/ Voice Messages OK/ Text OK

Home Phone: _____ No Messages/ Voice Messages OK

Work Phone: _____ No Messages/ Voice Messages OK

Emergency Contact 1 _____ Relationship _____

Number _____

Emergency Contact 2 _____ Relationship _____

Number _____

I have received the HIPAA agreement and have reviewed confidentiality with the facilitator

_____ _____

(Name or Name of guardian – if under 18) (Date)