**CONFIDENTIALITY AGREEMENT FOR STUDENTS**

I understand that I may come in contact with various types of information in my time at Flourish Integrated Therapy, LLC. This information may include, but is not limited to, information on patients, employees, plan members, students, other workforce members, donors, research, and financial and business operations (collectively referred to as "Confidential Information"). Some of this information is made confidential by law (such as "protected health information" or "PHI" under the federal Health Insurance Portability and Accountability Act) or by Flourish Integrated Therapy, LLC policies. Confidential Information may be in any form, e.g., written, electronic, oral, overheard or observed. I also understand that access to all Confidential Information is granted on a need-to-know basis. A need-to-know is defined as information access that is required in order to engage in my learning, observations, or to complete my approved academic requirements through my school or university.

By signing below, I agree to the following:

- I will protect the confidentiality of all Confidential Information of Flourish Integrated Therapy, LLC
- I will not share personal information with those outside of Flourish
- I will not remove any Confidential Information from Flourish
- I will not post or discuss Confidential Information, including pictures and/or videos on my personal social media sites (e.g. Facebook, Snapchat, etc.). Likewise, I will not post or discuss Confidential Information on Flourish-sponsored social media sites without the appropriate approval in accordance with established Flourish policies and procedures.
- I will not access, maintain or transmit Confidential Information on any unencrypted portable electronic devices (e.g. Androids, iPhones, iPads, etc.) and agree to use such devices in accordance with Flourish's policies only.

If I knowingly violate this agreement, I will be subject to being asked to end my experience at Flourish Integrated Therapy. In addition, under applicable law, I may be subject to criminal or civil penalties.

I have read and understand the above and agree to be bound by it. I understand that signing this agreement and complying with its terms is a requirement for being a student volunteer at Flourish Integrated Therapy.

Name (Print): _____ Daytime Phone: _____
Signature: _____ Date: _____

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Columbus, OH 43235

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# WAIVER, RELEASE AND HOLD HARMLESS AGREEMENT

This Waiver, Release and Hold Harmless Agreement ("Agreement") is made as of (date) _____ (the "Effective Date"), by and between Flourish Integrated Therapy, LLC ("Flourish") and _____ ("Client").

RECITALS

WHEREAS, Flourish provides out-patient therapy services from certain medical office locations which
WHEREAS, the Client desires to avail itself of Flourish's services, and;

WHEREAS, significant health concerns exists regarding a known pandemic due to the transmissibility of the Covid-19 virus which can infect a client and cause an undetermined level of illness, including death ("Covid Pandemic"); and,

WHEREAS, notwithstanding the Covid Pandemic, medical offices are authorized and permitted by Federal, State and Local authorities to open and operate in order to provide its services to the Client, and,

WHEREAS, the Client understands that notwithstanding any reasonable precautions taken by Flourish to reduce introduction to infection, the Client risks infection in pursing all day to day activities including but not limited to seeking services from Flourish;

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, and for the mutual covenants stated herein, the parties hereto agree as follows:

AGREEMENT

1. Waiver and Release. In consideration of Flourish providing services to Client, Client hereby waives and releases any and all claims against, and holds Flourish and its owners, officers, executives, successors and assigns harmless from and against any and all claims, liability, damages, costs, fees, fines, debt, expenses (including attorney's fees) or actions, known or unknown, foreseen or unforeseen, which Client may hold, claim, or for which Flourish is otherwise alleged to be liable as a result of any death, disability, harm or injury to the Client from illness or infection due to the Covid Pandemic or as a result of any act or omission of Flourish in operating its facilities and offering its services for Client's use which is alleged to have resulted in Client's infection by the Covid virus.

It is expressly acknowledged by Client that in seeking Flourish's services Client has assumed the risk of contracting any illness or disease due to the Covid Pandemic as a result of visiting Flourish's offices and seeking Flourish's services.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

CLIENT:

Print: _____

Sign: _____

Date: _____

# STUDENT EMERGENCY CONTACT FORM

Name: _____
Department: _____

**Personal Contact Information:**

Home Address: _____
City, State, Zip: _____
Cell #: _____

**Emergency Contact Information:**

(1) Name: _____ Relationship: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Work Numbers: _____ Employer: _____

**Emergency Contact Information:**

(2) Name: _____ Relationship: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Work Numbers: _____ Employer: _____

**Medical Contact Information:**

Doctor Name: _____ Phone Number: _____

**I have voluntarily provided the above contact information and authorize Flourish Integrated Therapy LLC and it's representatives to contact any of the above on my behalf in the even of an emergency.**

**Student Signature:** _____ **Date:** _____

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# Volunteer Release and Waiver of Liability Form for Student Volunteer

**Important-** Flourish Integrated Therapy, LLC appreciates the assistance of its volunteers. As a volunteer, you will play a role in assisting the practice and our community. Before the volunteer may begin your volunteer assignment, you will need to acknowledge that you have agreed to the terms of this release. You and your parents or legal guardians should read it carefully before signing it.

**Waiver and release of claims.** I understand that during the course of my volunteer activities with Flourish Integrated Therapy, LLC, dangerous hazards may arise. I assume the risk of injury and I fully and completely release, waive, and discharge Flourish Integrated Therapy, LLC, including its officers, employees, agents, and affiliated entities, from any and all liability, losses, injuries, death, damage, and any other claims connected in any to my volunteer activities from Flourish Integrated Therapy, LLC. This release includes any claim that may arise due to first aid, medical treatment, or other services rendered to me. Additionally, I agree to pay for the costs of any claims, including attorney's fees, that are made or threatened against Flourish Integrated Therapy, LLC or its officers, employees, agents, and affiliated entities arising out of any of my volunteer activities. I agree that this release is intended to be as broad and inclusive as permitted by the laws of Ohio, which govern the application and interpretation of this release. I understand that should any part of this release be ruled invalid by a court, the other parts will remain valid and continue to be in effect.

**Volunteer status.** I understand that I am an unpaid volunteer for Flourish Integrated Therapy, LLC. I waive all claims for compensation from Flourish Integrated Therapy, LLC for any services I performed in connection with my volunteer assignment at Flourish Integrated Therapy, LLC. When performing volunteer services, I understand that I am not an employee of Flourish Integrated Therapy LLC and I am not entitled to any employee benefits. Flourish Integrated Therapy, LLC does not have any responsibility to provide any health, medical, disability, or any other insurance coverage for me. It is my responsibility as a volunteer to ensure that I have insurance coverage if I want it. I understand that I will not be entitled to works' compensation coverage.

**Photographic release.** I grant to Flourish Integrated Therapy, LLC the unlimited right to use photographic images and video or audio recordings of me that are made by Flourish Integrated Therapy, LLC or others during my volunteer assignment for Flourish Integrated Therapy, LLC, including any royalties, proceeds, or other benefits from the use of these photographs or recordings.

**Background check.** I understand that a criminal history and background check should be obtained prior to my appointment as a volunteer. My signature below certifies that I agree to a criminal history check and gree to provide Flourish Integrated Therapy, LLC with any other information required to perform a criminal history or background check. If asked, the code 475570 can be used on your background check.

**Our policies.** I agree to follow and abide by all Flourish Integrated Therapy, LLC policies, including those that forbid discrimination and harassment.

**Term of assignment.** After my volunteer assignment begins, I understand that Flourish Integrated Therapy, LLC may terminate the assignment at any time for any reason.

_____ | _____ _____
Volunteer's Signature Printed Name Signature Today's date

_____ | _____ _____
Volunteer's Guardian Printed Name Signature Today's date

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