Consolidated Consent for Treatment

Medical Record #:_____

Please read the following carefully and initial each signature field below where affirmation is provided:

___ Consent for Treatment

I consent to treatment and care for myself or as legal guardian of the patient in question. I am aware that my care and treatment might include any of the following services:

- ⇨ Emergency and routine behavioral health or primary health treatment; whether inpatient or outpatient.
- ⇨ Laboratory tests to include blood, urine, and other bodily fluids/tissue collection and analysis. I understand that drug screens' results are not used for the sole purpose of treatment decisions and/or termination from treatment Medication management.
- ⇨ Other routine care which, may be considered necessary or advisable for diagnosis, treatment, healthcare operations and/or payment.

___ Patient Rights and Responsibilities

I have received and read Henderson's Patient Rights and Responsibilities Statement. I have had the opportunity to ask questions and agree with the terms of this policy statement.

___ Notice of Privacy Practices

I have received and read Henderson's Notice of Privacy Practices. I have the opportunity to ask questions and agree with the terms of this policy.

___Orientation Packet

I acknowledge I have received the orientation packet and know it is located on HBH website. I have been given the opportunity to ask any questions as it relates to the content of this packet.

____ Insurance and Payments

For any insurance that I may now or in the future have, I agree that Henderson will submit claims for third-party coverage to any and/or all of insurance carriers that I disclose to Henderson or that Henderson may come to know that I have. I authorize Henderson to complete any forms which are needed in order to obtain payment from third-party payers, including Medicare and Medicaid, commercial insurance carriers and all insurance or funding programs in connection with my treatment. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I hereby authorize payment of insurance benefits to Henderson Behavioral Health and assign all insurance benefits due under any and all medical policies covering me insofar as they are necessary to cover the costs care. In the event that payment is received causing overpayment for this visit, I authorize application of the overpayment to any unpaid Henderson bill for which I am responsible. I guarantee payment of any charges by Henderson Behavioral Health for services rendered and not covered by a third-party payor, which may include fees for services, deductibles

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or co-pays. I understand that I am eligible for sliding scale fees based on income and that such sliding scale will determine payment amounts due. Payment is due, in full, within 90 days from the date of services, unless arrangements are made with an authorized agent of Henderson Behavioral Health. I agree to allow Henderson Behavioral Health or its agents, to access credit history and my current credit score for unpaid account balances and financial assistance application.

___ Communication by cellphone, text or email

I agree that Henderson may communicate with me through ___ phone calls, ___ text messages and ___emails.

I understand that I am giving express consent to Henderson or its third-party contractors to contact me (including through an automatic telephone dialer) via telephone call, text message or email at the phone number(s) and/or email address(es) provided about payment and healthcare-related activities, including, but not limited to:

- ⇨ Appointment confirmations and reminders
- ⇨ General health reminders, such as flu shot, immunizations
- ⇨ Patient health and experience feedback
- ⇨ Servicing my account
- ⇨ Collecting amounts due

___Telehealth Services

Should I request TELEHEALTH services, I understand that my treatment team may provide such services should they determine that TELEHEALTH is the appropriate means of best providing care. If TELEHEALTH is approved and provided for one or more sessions throughout the course of my treatment, I agree to abide by the HBH Telehealth Policy which I have read, understood and agree to abide by for any and all TELEHEALTH sessions.

____ I understand that this consent may be revoked in writing by me at any time. Furthermore, I know I can refuse to consent to any treatment whatsoever, to the extent allowed by law. Please note that there are situations in which you may be treated and prohibited from leaving our crisis stabilization center even if you refuse. Also note that revoking this consent will not change actions that have been taken while the consent was in place.

If the patient is a minor or lacks capacity, the signature of the Power of Attorney for Healthcare, parent, guardian or closest relative is required.

Patient Signature: _____ Date: _____

Relationship to patient, if not patient (please print): _____

Witness Signature: _____ Date: _____