Adult & Child – Consent Agreement

Patient ID: _____

1. FINANCIAL AGREEMENT:
I agree to pay in full for all services and supplies received by me or the designated patient from Adult & Child Health. I agree to pay at the time of the services or supplies, unless special arrangements are made by me, the managed care organization, or the insurance carrier.

2. ASSIGNMENT OF INSURANCE BENEFITS:
For the term of my current treatment episode, I authorize Adult and Child to release all information, **including drug and alcohol or HIV records** necessary for a payer or insurer to process and adjudicate a claim for payment for services rendered to the patient or the patient's participating representative. I understand also that information may be disclosed to the Indiana Department of Mental Health and Addictions, as it supports Adult and Child as a funding source and regulatory body. I also authorize the release of all clinical information necessary to obtain precertification for necessary services from a payer/insurer. I understand that my payer may make limited claims data available to understand my overall healthcare needs and I authorize my A&C treatment team to use such data in as much as it facilitates medically necessary care coordination. It is my responsibility to notify Adult and Child of any changes to insurance and to supply Adult and Child with any documentation or information necessary to file claims. If my insurance company(s) pays nothing or only a portion of the charge(s), I will be required to pay the balance of the account. While insurance companies' policies differ in paying for services, I am responsible for all fees on services not covered by my insurance policy, including deductibles and co-payments. I authorize payment to Adult and Child for insurance or any other third party benefits payable to me. I also understand that verification of benefits by Adult and Child does not guarantee payment from third party carriers. These benefits will be determined at the time claims are processed by third party carriers. I further understand that this consent for payment may be revoked by me in writing at any time except to the extent that action based upon the release has already been taken.

3. APPOINTMENT AGREEMENT:
I understand that my appointment times are being reserved for me and that efficiency of scheduling often depends on my keeping my appointment as scheduled. I understand that repeated missed appointments may delay my treatment progress and failure to cancel 24 hours before an appointment is considered a no-show.

4. CONFIDENTIAL USE OF PROTECTED HEALTH INFORMATION:
The Adult and Child Notice of Privacy Practices gives an in-depth description of reasons for access to your protected health information, where consent is required and when it is not necessary. Signing below acknowledges receipt of the Adult and Child Notice of Privacy Practices and that the Patient Rights and Responsibilities were explained orally and offered in written format.

5. CONSENT FOR HEALTH SERVICES:
I, the undersigned, agree and consent to participate in the health (i.e., mental health/addictions/primary care) services offered and provided by Adult and Child as defined in Indiana law. I have also received notification of my rights of confidentiality of alcohol and drug abuse patient records. I understand that I am consenting and agreeing only to those health services that my assigned providers are qualified to provide within:

a) the scope of the provider's license, certification, and training; or
b) the scope of license, certification, and training of those mental health providers directly supervising the services received by the Patient.

☐ (initial) PERMISSION TO TRANSPORT DEPENDENT: As applicable, in the event I cannot bring my minor child or the person for whom I am legal guardian/custodian to the Program, I give Adult and Child permission to bring the patient to the Program and participate in treatment as needed.

☐ (initial) PHOTOGRAPHS: I give my permission for A&C staff to photograph me for internal identification, diagnostic, treatment or educational purposes. I understand that I may rescind this consent at any time. Please initial in the box to confirm agreement.

☐ (initial) APPOINTMENT NO SHOWS: A&C may restrict your right to obtain routine outpatient care (limit care to crisis-only support) from A&C should you have two (2) no-show appointments in less than a six (6) month period.

☐ (initial) PAYER CLAIMS DATA: I understand that my payer may make limited claims data available to understand my overall healthcare needs and authorize my A&C treatment team to use such data in as much as it facilitates medically necessary care coordination.

The undersigned certifies that he/she has read the foregoing, is the patient, or the patient's parent or guardian, and agrees to and accepts the terms of the above.

* If a minor (under 18 y/o) is receiving substance abuse services, he/she must sign the consent in addition to the parent/guardian.

Patient/Guardian Signature:_____ Date: _____

Witness Signature:_____ Date: _____

Guardian Relationship:_____

FOR OFFICE USE ONLY: % of Discount: _____
Income Verified: ◯ Yes ◯ No Approved: ◯ Yes ◯ No
HAP Eligible: ◯ Yes ◯ No
Expiration Date: _____