OUTPATIENT PRACTICE
CONSENT TO TREATMENT, FINANCIAL AGREEMENT, AUTHORIZATION FOR REQUIRED RELEASE OF INFORMATION and REQUIRED DISCLOSURES

I understand this document is a Consent to Treatment and a Financial Agreement for outpatient treatment by Lindner Center of HOPE Professional Associates (LCOHPA), an Authorization for Required Release of Information and Required Disclosures.

1. Consent to Treatment

a. **Consent to Treatment:** I hereby voluntarily consent to mental health or co-occurring disorder treatment and authorize the administration and performance of treatment by LCOHPA as considered necessary for my condition, or the condition of the patient named below, as directed by a physician, psychologist, independent licensed social worker, certified chemical dependency counselor, advance practice nurse, case manager, or other health care practitioner.

b. **Telehealth Consultation**: If my healthcare provider and I decide to engage in a telehealth consultation, in which my visit will be conducted remotely via telehealth technology, I agree to the following: I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format. I understand that the audio and/or video conference the technology used to perform the consultation will not be the same as a direct patient/healthcare provider visit, because I will not be in the same room as my healthcare provider. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare information may be shared with other individuals for treatment, payment, and/or healthcare operations purposes such as for scheduling or billing. Others involved in my care may also be present during the consultation other than my healthcare provider, and I will be informed of their presence in the consultation and will have the right to terminate the consultation at any time. I understand that electronic communications may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependency, etc.). I understand that my healthcare provider or I can discontinue the telehealth consult visit if it is felt that the audio and/or videoconferencing technology is not adequate for the situation. I understand there is no guarantee the telehealth sessions will eliminate the need to see my healthcare provider in person. I understand that the alternative to a telehealth consult/visit is an in-person visit. I understand I may ask questions prior to having a telehealth consultation. By signing below, I acknowledge that I have read and understand the risks and benefits of a telehealth consultation, and I wish to proceed with the telehealth consultation.

c. **Medical Education Acknowledgement:** I agree that interns, residents, fellows, nurses, medical students, and other health personnel in training may participate with or assist my clinician(s), or the clinician(s) of the patient named below.

d. **Health Status and Medical History:** I understand that it may be important to the development of my personalized treatment plan or that of the patient named below for LCOHPA to have a complete understanding of my health status and medical history, or that of the patient named below, and acknowledge that I may be asked to authorize LCOHPA to obtain such information from healthcare providers who have previously treated me or the patient named below. I further acknowledge that I may be asked to offer my specific consent and authorization to permit LCOHPA to obtain this information about me or the patient named below.

e. **No Guarantee**: I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the outcome of the treatment to be rendered by LCOHPA. I understand that there may be some risks from some medications if I am, or the below named patient is, pregnant. I know that it is my responsibility to discuss possible pregnancy with the clinicians and staff involved in my care.

I understand that if I, or the patient named below, refuses treatment, medication, or other therapeutic services, Lindner Center is not responsible for any ill effect the decision may cause.

f. **Right to Revoke:** I understand that I may revoke my consent at any time and that this decision is mine alone. This consent shall remain in full force and effect until revoked in writing.

2. <u>Financial Agreement</u>

a. **Financial Responsibility**: Subject to applicable law and the terms and conditions of any applicable contract between LCOHPA and a third-party payer (such as an insurance company, an employer-sponsored group health plan, or Medicare or another governmental health care program), and in consideration of all health care services rendered or about to be rendered to me or the patient named below, I agree to be financially responsible and obligated to pay LCOHPA for the total charges of the services received that are not paid under the "Assignment of Benefits" made below. I also agree to pay LCOHPA, at the time of service, any applicable actual or estimated co-payment or co-insurance for the health care services rendered during the visit at LCOHPA.

b. **Assignment of Benefits**: In consideration of all health care services rendered or about to be rendered to me or the patient named below, I hereby authorize payment from and assign to LCOHPA all rights, title and interest in and to any benefits or amounts due from any and all insurance policies, employer-sponsored group health plans, and/or any other responsible private or governmental third-party payers in an amount not to exceed LCOHPA's regular and customary charges for the health care services rendered. I consent to any request for review or appeal by LCOHPA to challenge a determination of benefits made by any private or governmental third-party payer. Except as otherwise required by law, I assume responsibility for determining in advance whether the services provided to me, or the patient named below, are covered by any private or governmental third-party payer.

c. **Telehealth Consultation Billing**: If my healthcare provider and I decide to engage in a telehealth consultation, in which my visit will be conducted remotely via Telehealth technology, I understand my healthcare provider may bill for services provided as part of the telehealth sessions. Telehealth billing information is collected in the same manner as a regular office visit. I understand I am financially responsible for each telehealth session, and it is my responsibility to check with my insurance plan to determine coverage.

d. **Claims Submission Certifications/Self Pay Request:** I understand the information in this document or otherwise given by me to LCOHPA may be used in submitting claims for payment for services rendered to me or the patient named below, and I certify that such information is correct. I authorize a copy of this document to be used in place of the original, and the use of "signature on file" on all claims submissions. I understand that I am responsible for notifying LCOHPA of any pre-certifications or referrals required by my health plans or the health plans of the patient named below. In the event any account becomes delinquent and collection activity is required to collect payment, I agree to pay all reasonable attorney fees and collection agency costs and/or fees associated with the collection of any unpaid balance.

I understand that, I may request that claims for payment for services rendered to me or the patient named below not be submitted. If such a request is made, I agree to be financially responsible and obligated to pay LCOHPA for the total charges of the services received.

e. **Independent Clinicians**: I understand that some of the clinicians who render professional services at Lindner Center are independent practitioners and are not employees or agents of Lindner Center. Lindner Center is not responsible for the acts or omissions of clinicians who are not directed or controlled by Lindner Center.

f. **Signature:** I understand that by signing this document, I become liable for all amounts incurred for patient care and other related services rendered by LCOHPA.

g. **Notice for Medicare Patients:** Patient's certification, authorization to release information and payment request: I certify that the information provided by me, or the patient named below, in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me or the patient named below to release to the Social Security Administration, the Center for Medicare and Medicaid Services, and/or its intermediaries or carriers any information needed to adjudicate or address any Medicare claim relating to the provision of health care items or services. Similarly, I authorize the Social Security Administration, the Center for Medicare and Medicaid Services, and/or its intermediaries or carriers to release information about me or the patient named below in order to establish Medicare entitlement or to adjudicate or address any Medicare claim relating to the provision of health care items or services. I request that payments of authorized benefits be made to me or on my behalf or on behalf of the patient named below. I assign the benefits payable for practitioner services to the practitioner or organization furnishing the services, or authorize such practitioner or organization to submit a claim to Medicare for payment to me. I understand that if, under Medicare program guidelines, a necessary service is determined to be non-covered, I will personally be responsible for payment as set out above under the "Financial Agreement".

3. <u>Medical Records/Release of Information</u>

a. **Release of Records for Compliance or Performance Improvement Purposes**: I authorize the release of medical records information, and I specifically authorize the release of information concerning treatment relating to HIV testing, AIDS or AIDS related condition, treatment of mental health or psychiatric condition(s), and/or treatment of alcoholism or drug abuse to insurance carriers or their associates, third-party payers or their representatives, the Social Security Administration or other authorized governmental agency, and/or review organizations as deemed necessary to establish or verify my benefits entitlement, or that of the patient named below, for LCOHPA or clinician claims for services rendered and to process payment claims and obtain reimbursement from such third-party payers for the health services provided. I also authorize my records, or the records of the patient named below, to be released to state, federal, or other surveyors for accreditation and/or regulatory licensing purposes and to others engaged in health care operations such as training, credentialing, quality improvement, legal compliance, contracting, and administration. I also authorize release of my medical record information, or that of the patient named below, as required or permitted by law. For example, cases of HIV, tuberculosis, viral meningitis, and other communicable diseases may require mandatory reporting to organizations such as health departments or the Centers for Disease Control and Prevention. The authorization provided in this section will expire five years after the date of discharge. I am aware that I can revoke, in writing, this authorization at any time except to the extent that action has been taken in reliance thereon.

b. **Release of Medical Records for Treatment Purposes**: I authorize the release of medical records information, and I specifically authorize the release of all information concerning treatment relating to HIV testing, AIDS or AIDS related conditions, and/or treatment of mental health or psychiatric condition(s), to other health care providers who utilize an electronic medical record system compatible with the LCOHPA records system only for the purposes of providing treatment to me, or the patient named below. The authorization provided in this section will expire five years after the date of discharge. I am aware that I can revoke, in writing, this authorization at any time except to the extent that action has been taken in reliance thereon. I understand that if I refuse or revoke this authorization LCOHPA will not deny any treatment to me or the patient named below.

c. **Photography**: I understand and agree that I, or the patient named below, will be photographed for purposes of identification, helping to assure safety, and assisting in certain health care operations of LCOHPA, such as performance improvement programs.

d. **Electronic Prescribing:** I hereby consent to and authorize LCOHPA and its affiliates, including physicians or other prescribers providing treatment to me or the patient named below at a LCOHPA facility, to access or input prescription benefit or medication history for me, or the patient named below, on the Surescripts Network or other electronic prescription services.

e. **Medical Records Access and Retention:** Medical records of LCOHPA are kept on file for the period of time designated in LCOHPA's document retention policy and then destroyed. Subject to appropriate authorization or applicable law, I understand that every patient or his or her legal representative has a right to inspect and obtain a copy of his or her medical record. There will be a charge for this service.

f. **Medical Research:** I understand that Linder Center of HOPE is a research facility. As such, I grant the Lindner Center of HOPE research treatment team access to my records or those of the patient named below to determine if I or the patient named below may be eligible for a current or potential study. This consent involves only the review of records. Additional information and consents would be provided in the event that I or the patient named below is considered for a study.

g. **Contact Information:** I have voluntarily given my cell phone, home phone, and/or other contact number so that I may be contacted. I authorize LCOHPA or its agents to contact me at any telephone number associated with my account, including wireless telephone numbers or other numbers that may result in a charge to me, whether provided in the past, present, or future. I also authorize contacts and messages by automated dialers and other mechanical devices that may or may not leave messages regarding my account or that of the patient named below, such as for purposes of collection services and appointment reminders.

4. **Patient Information Packet**: I acknowledge receipt of the LCOHPA Patient Information Packet, which includes a listing of patient rights and responsibilities, information about the grievance process, and the Notice of Privacy Practice. The materials have been explained to my satisfaction.

5. **Disclosures:** I attest that I or the patient named below :

   - is not a registered sex offender of any state, and
   - is not seeking criminal court appointed mental health treatment or evaluation or as a condition of my probation or parole.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND ACKNOWLEGEMENTS INCLUDED IN THIS DOCUMENT.

_____ _____

Patient Signature **Current Date/Current Time**

☐ Patient

☐ ClosestRelative

☐ Legal Guardian

_____ _____

Witness **Current Date/CurrentTime**