Form 114a Consent to Use Protected Health Information

NORTHERN PINES MENTAL HEALTH CENTER TREATMENT CONSENT FORM

1.____ (INITIAL) **CONSENT FOR TREATMENT**
I understand that as in all types of medical and psychological treatment, there are certain risks. This includes the general risk that there may be emotional pain, stress, and/or life changes associated with mental health and/or chemical dependency treatment; and although mental health and/or chemical dependency treatment helps many individuals, it is not always completely effective. I hereby give written consent for mental health/chemical dependency treatment. My clinician will inform me of other specific treatment risks that may be involved in my case, and/or I will ask any questions I may have about specific treatment risks.

2.____ (INITIAL) **CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION**
I consent to the release of protected health information that is required to carry out treatment, payment, and healthcare operations on my behalf. ***If I am or will be working with more than one Northern Pines provider or program, I consent to all the Northern Pines providers and programs I am engaged with sharing my Northern Pines health information in order to facilitate better care coordination***. I acknowledge that I have received and read the Northern Pines Mental Health Center Notice of Privacy Practices.

3. ____ (INITIAL) **RELEASE TO INSURER/BENEFIT ASSIGNMENT**
I request payment of authorized health insurance, CCDTF, Medicare, and/or Medicaid benefits be made on my behalf to Northern Pines Mental Health Center for as long as there is a balance due. I authorize the disclosure of only the mental health information required to determine payment of my bill, payment of claims, fraud investigation, and/or quality of care review studies to the appropriate payer. I have received a copy of the Financial Policy Handout, and I understand I may be eligible for a sliding fee structure and that if payment is not received, then an outside collection agency may be utilized. I do agree to pay for all services provided to me, my spouse, and/or minor children including all charges not covered by insurance payment or by CCDTF funding.

4.____ (INITIAL) **CONSENT FOR REPORTING MALTREATMENT OF VULNERABLE ADULTS**
Federal law and regulations protect the confidentiality of a client's alcohol and drug abuse records maintained by this program. Federal law specifically prohibits a person from disclosing client identifying information in connection with a report of suspected abuse or neglect unless the vulnerable adult/ legal representative has consented to disclosure in a manner which conforms to federal requirements. By signing, I acknowledge that I understand this notice and Northern Pines has permission to provide County Social Services with a verbal/ written report if I have been identified as a victim or alleged perpetrator of maltreatment.

5.____ (INITIAL) **POLICY REGARDING THE FAILURE TO KEEP APPOINTMENTS**
I understand that if I fail to keep appointments or repeatedly cancel appointments, I may not be able to schedule my own appointments with my therapist. Instead, I will be provided with an appointment time to see my therapist when more than one client will be scheduled. I will then be seen on a "first come, first serve" basis.

6.____ (INITIAL) **PHYSICIAN/MEDICAL CLINIC CONTACT**
Do you want Northern Pines Mental Health Center to provide information about your treatment to your primary care physician/medical center? (Check one) Please note that Northern Pines Mental Health Center can not guarantee the confidentiality of any information by another entity once we release the information.

____No ____ Yes If yes, name of physician or medical center: _____

7.____ (INITIAL) **APPOINTMENT REMINDERS**
Can we call/text to remind you of an appointment? (This does not guarantee a reminder call.) **It is either all appointment reminders or no appointment reminders, we are unable to differentiate text messaging between the different programs**

____No ____Yes If yes, telephone number to call: _____

8.____ (INITIAL) **CONSENT FOR TEXT MESSAGING AND EMAIL COMMUNICATIONS**
By signing consent it is understood that text messages and e-mails are not always answered immediately and will only be answered on the following business day during regular business hours. I understand when in crisis, do not text, but rather contact the crisis line at (800) 462-5525. I also understand that if harm statements are texted and you do not answer a phone call immediately, parents and/or law enforcement will be notified immediately to do a welfare check. I understand that Northern Pines Mental Health Center is not responsible for text message (SMS and/or MMS) charges or overages. Picture messages are not part of this consent and should not be used. I understand I am responsible to let Northern Pines Mental Health Center know if my phone number changes.

____No ____Yes If yes, telephone number to call/text: _____

____No ____Yes If yes, email address to be used: _____

9.____ (INITIAL) **TRANSPORTATION OF CHILDREN REQUEST (DIVISION SPECIFIC)**
I hereby authorize that Northern Pines employees can transport my child. This is a requirement when transporting children without their parent or guardian.

Note: Northern Pines Mental Health Center does not use any social media with clients such as Facebook, Twitter & Snap Chat, etc.

THIS TREATMENT CONSENT WILL REMAIN IN EFFECT UNLESS I CHOOSE TO REVOKE IT IN WRITING.

_____
Client's Printed Name

_____ _____
Client's Signature Date

_____
Witness

AUTHORIZATION TO PROVIDE SERVICES TO MINORS

I am a legal guardian, and I give my permission for the Northern Pines Mental Health Center staff to provide evaluation and treatment services to my child. I agree to pay for all services provided to my minor child including all charges not covered by insurance. I also understand that the child's other parent will have access to the mental health records unless I provide proper documentation that the other parent does not have this legal right.

Child's Name: _____ Birthdate: _____ / _____ / _____

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____ Date: _____

Witness: _____