Release Treatment Consent

1. 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 substance use disorder treatment; and although mental health and/or substance use disorder treatment helps many individuals, it is not always completely effective. I hereby give written consent for mental health/substance use disorder 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. CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I consent to the release of protected health information including Alcohol & Drug Abuse Records, (42 CFR Part 2: and/or HIPPA 45 CFR) 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. RELEASE TO INSURER/BENEFIT ASSIGNMENT

Insurance requires that I attest to the following: 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 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. I agree that I will be financially responsible for making payments to Northern Pines Mental Health Center for anything deemed as co-insurance, deductible, copay, plan exclusions, non-covered services, and other services that health plans, Medicare, and Medicaid deem as patient responsibility. I understand that services are sometimes not covered by insurance, where I accept financial responsibility. These services include, but are not limited to, skills (H2017 and H2014). I am responsible for checking benefits and limitations independently with my insurance health plan. I understand that if I would like a cost estimate for services, I am responsible for requesting this information from Northern Pines Mental Health Center. 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. If I elect to pay for services out-of-pocket, I understand that I will be fully responsible for these charges. I understand that by my election to self-pay for services, any payments made will not be credited towards satisfying my deductible or out-of-pocket maximum with my health plan. I understand that if electing to self-pay for services while having available insurance coverage will disqualify my ability to apply or receive any type of funding through Northern Pines Mental Health Center. I understand that if I do not provide Northern Pines Mental Health Center full and accurate insurance information needed for claim submission at the time of service, I will be fully responsible for all charges at full fee. I understand that if I choose to utilize and provide Northern Pines Mental Health Center with insurance information after the service is rendered, that I accept financial responsibility for the services in the occurrence of a timely filing denial from the health plan.

I understand that if my insurance plan is out-of-network, that I have the right to waive NPMH's normal process. I also understand that I can request a cost estimate for my services at any time.

4. 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 maltreatment 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 DHS vulnerable adult entry point at 844-880-1574 with a verbal/written report if I have been identified as a victim or alleged perpetrator of maltreatment.

5. 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. APPOINTMENT REMINDERS
Can we call/text/email to remind you of an appointment? Note: By selecting yes on the question below, you may receive appointment reminders for every service type. For example, if you have 5 appointments this week, you may receive 5 separate reminders.
SIGN UP ON SIGNATURE PAGE IF YOU WOULD LIKE REMINDERS

7. CONSENT FOR PRESCRIPTION HISTORY
By signing this consent form you are agreeing Northern Pines Mental Health may request and use your prescription medication history from other healthcare providers and/or third parties for treatment purposes.

8. TRANSPORTATION OF CHILDREN REQUEST (CTSS ONLY)
I hereby authorize that Northern Pines employees can transport my child. This is a requirement when transporting children without their parent or guardian.

9. 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 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.

10. TREATMENT CONSENT EXPIRATION
This treatment consent will expire in one year from the date I sign or unless I request an earlier expiration in writing.

ALCOHOL AND/OR DRUG ABUSE CONSENT FOR TREATMENT
I am a Substance Use Disorder Services client:
PICK ANSWER ON SIGNATURE PAGE

By initialing ***INITIAL ON SIGNATURE PAGE***
I release my Alcohol and/or Drug information.
No information regarding Alcohol and/or Drug Abuse treatment will be provided unless you authorize by initialing: As a Substance Use Disorder Services Client I authorize this release to be given to a court services office relating to a criminal sentence. I understand I cannot withdraw this consent for 60 days or until my legal status changes if I am here because of a court order related to a crime. This information is protected by federal law. Federal regulations (42 CFR part 2) prohibit further disclosure of it without your specific written consent or as otherwise permitted by such regulations. A general authorization for releases of medical or other information is NOT sufficient for this purpose.
I authorize the release of my records to a court services office relating to my criminal sentence:
PICK AN ANSWER ON SIGNATURE PAGE