Community Mental Health Center, Inc.
...your partner in behavioral health
285 Bielby Road Lawrenceburg, Indiana 47025
812-537-1302

Consent to Treatment

Client Name:	Client #:	Date:

Staff are to review each of the section of the Consent to Treatment.

I have received copies of the Client Rights and Responsibilities including Orientation Handbook.

I have received a copy of the Payment Policy.

Limited Access to Persons Involved in a Client's Care and for Notification Purposes
45CFR 16 4.510) HIPAA

The above named client has been advised that CMHC may use or disclose the Client's protected health information, not including mental health records, drug and alcohol treatment records, and communicable disease records, including HIV/AIDS records, to a family member or a relative, a close personal friend or any other person identified by the Client to the extent that protected health information is directly relevant to such person's involvement with the Client's care or payment related to the Client's treatment and to notify the person of the Client's location, general condition or death. Further, the Client has been advised that CMHC Inc may also use and orally disclose protected heath information, not including mental health records, drug and alcohol treatment records and communicable disease records, including HIV/AIDS records, to notify or assist, including but not limited to working with a private entity that assists in disaster relief efforts and the notification of (including identifying or locating) a family member, a personal representative or another person responsible for the Client's care, of the Client's location, general condition or death, and the Client does not object.
Note: If client objects then complete form for Objection by Client to Limited Access.

Notification of Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations. Generally, the program may not say to a person outside the program that a patient attends the program or discloses any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing,
2. The disclosure is allowed by a court order or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation.

Violation of the Federal Law and Regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations. Federal Law and Regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal Laws and Regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or local authorities. Any disclosure of protected health information to any entity or person is accompanied with the following statement, which prohibits re-disclosure of the released or disclosed Protected Health Information: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure unless expressly permitted by written consent of person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
I verify receipt of the above written information as notification of Federal Law regarding confidentiality of alcohol and drug abuse client records.

Authorization for Third Party Billing and Consent for Treatment

I hereby authorize and give permission to the staff of CMHC to render treatment or services to me or the indicated client for whom I am legally responsible.
I hereby authorize that CMHC staff, who are not directly involved with my treatment may be consulted to determine what might be most helpful for my care and/or the care of my child and family. For example, group leaders and my therapist; or case managers and my prescriber may consult with one another. In such cases, only the minimal amount of information necessary will be shared. All CMHC staff are held to a high standard of confidentiality and will maintain my protected health information in a private and sensitive manner.
I hereby acknowledge that the cost of treatment and services has been discussed with me. I further acknowledge that the collection and billing policies of CMHC have been explained and I understand that I am responsible for payment under the following terms:

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Client Name:	**Client #:** :	**Date:**

I will pay the full fee for services received less the amount of subsidy allowed by CMHC policy for all services for which I am financially responsible at the time services are provided until this account is paid in full. I understand the total amount collected from me or my insurance shall not exceed the full service charged and any overpayment will promptly be refunded to the appropriate party.

I hereby authorize the release of information necessary for the processing of third party claims. I understand that the information to be released will be only that information required by the third party payer to process claims for payment of services rendered by CMHC. I also understand that, unless otherwise indicated, this authorization extends to any drug or alcohol treatment information that may be contained in my record.

I understand that this authorization to release information is not required as a condition for treatment, and that my consent may be revoked, in writing, by me at any time except to the extent that action has already been taken. In the absence of such written revocation, this consent will expire upon final disposition of all third party payer claims.

I hereby authorize the direct payment to CMHC of any insurance or third party benefits otherwise payable to me.

Consent to receive text messages.

I agree to receive text message reminders about my appointments. I understand that depending on my contract, that I might incur charges for text messages.

Consent to participate in telehealth.

I understand that my services may be provided through telehealth (Zoom or a similar secure videoconferencing program or phone). I will be informed of the intent to provide service via telehealth prior to the appointment and have the right to request an in-person appointment with the understanding that this may result in a change of provider. Additionally, if my provider believes that it would be beneficial for me to be seen in person, I understand that telehealth may not always be an option for me. I also waive my right to confidentiality of my medical information if others around me can hear the provider or me when I am in my appointment. I understand that if my provider is only licensed in Indiana that I must be in Indiana at time of the appointment and that I may be asked my location when I am in a telehealth appointment.

I agree that all the above items were reviewed with me at the time of signature.

_____ _____
Signature of Client/Legal Guardian Date

_____ _____
Witness Date