285 Bielby Road Lawrenceburg, Indiana 47025
812-537-1302

Consent to Treatment

Patient Name:	Patient #:	Date:

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

I have received copies of the patient Client Handbook.

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

The above named patient has been advised that INcompass Healthcare may use or disclose the patient'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 patient to the extent that protected health information is directly relevant to such person's involvement with the patient's care or payment related to the patient's treatment and to notify the person of the patient's location, general condition or death. Further, the patient has been advised that INcompass Healthcare 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 patient's care, of the patient's location, general condition or death, and the patient does not object.

Note: If patient objects then complete form for Objection by patient 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 law 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. 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 patient records.

Authorization for Third Party Billing and Consent for Treatment

I hereby authorize and give permission to the staff of INcompass Healthcare to render treatment or services to me or the indicated patient for whom I am legally responsible.

I hereby authorize that INcompass Healthcare 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 INcompass Healthcare staff are held to a high standard of confidentiality and will maintain my protected health information in a private and sensitive manner.

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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 INcompass Healthcare have been explained, and I understand that I am responsible for payment under the following terms:

I will pay the full fee for services received less the amount of subsidy allowed by INcompass Healthcare 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 charge, 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 released will be only that information required by the third-party payer to process claims for payment of services rendered by INcompass Healthcare. 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 INcompass Healthcare of any insurance or third-party benefits otherwise payable to me.

Consent to Participate in Telehealth

I understand that my services may be provided through telehealth (Microsoft Teams 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 the time of the appointment and that I may be asked my location when I am in a telehealth appointment.

Consent to Attendance Policy

I understand and agree to follow the expectations of the cancellation and missed appointment policy. Missed appointments require a 24-hour notice for all cancellations. If you miss (late cancel or no-show) two or more appointments within 60 days, you may be discharged from treatment. You may access our crisis care services. If you would like to appeal against the decision you may contact the manager to discuss options for continuing treatment. I agree that all the above items were reviewed with me at the time of signature.

Consent to Participate in Artificial Intelligence (AI)

I understand that my provider may utilize artificial intelligence (AI), as a secure tool to assist them with administrative tasks like documentation. The AI utilized is a secure, HIPAA-compliant technology that embeds seamlessly within the existing EHR, and telehealth systems used by INcompass Healthcare. I understand that AI does not record sessions or directly interact with the client, nor does it provide any services or interventions. I will be informed by my provider of the intent to use AI during a treatment episode and have the right to request that the AI, audio version, not be used during the session.

Consent to receive electronic messages

I agree to receive text message reminders about my appointments. I understand that depending on my phone service contract, I might incur charges for text messages. I also agree that if I provide an email address to INcompass Healthcare, that I am responsible for the privacy of emails that may come to me from INcompass Healthcare.

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

_____ _____

Patient/Parent/Guardian Date

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_____ _____

Witness Date