Samaritan Center

Consent for Treatment/ Health Care Agreement

I _____, hereby voluntarily consent to the performance of mental health services including, but not limited to, screening, treatment, medication management, consulting and testing. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I acknowledge my care may be beyond the scope of my provider and I will be given resources or referrals for continued care. It is my responsibility to follow through with the recommendations explained to me by the provider.

I understand that this Consent for Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from Samaritan Center unless revoked by me in writing.

RELEASE OF MEDICAL INFORMATION: I understand that my prescriptions and prescription history will be sent, received, and shared electronically with other health providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just Samaritan Center, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I consent to have my provider access and view my or my child's claims medication history. I understand that I may revoke consent at any time in writing to the provider and they will immediately click revoke consent on claims medication page within their EHR service.

I acknowledge that I have received and reviewed the "Notice of Privacy Practices" and understand this document provides more information about how Samaritan Center and its workforce may use and/or disclose protected health information (PHI). I understand that my PHI includes some but not all of the following like diagnosis, test results, prescriptions, medical history, treatment, my progress or any other such related information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”). I understand my PHI will only be used or released for treatment, payment or healthcare operations, and as otherwise allowed by law. I understand Samaritan Center cannot be responsible for use or re-disclosure of information by third parties.

I consent and authorize Samaritan Center to release medical or other supporting information necessary to process my insurance claims and/or for the collection of payment for services from the above person/organization/company. I authorize payments of medical benefits to the Samaritan Center. However, I understand I am responsible for all deductibles and co-pays. I understand that I will be responsible for 100% of my charges should insurance not compensate the Center for my treatment. All charges and co-pays are payable and due at time of services.

USE OF CELL PHONE OR EMAIL: Samaritan Center, its affiliates and agents may use an automated telephone dialing system, texting, and email to contact the cellular telephone number(s) or email addresses that I provide to Samaritan Center for appointment and payment purposes.

Signature of Client: _____ Date: _____

Printed Name: _____

MINOR OR OTHER UNABLE TO CONSENT

If you are bringing a minor for treatment, you must remain at Samaritan Center until the session has concluded.

Client is a minor or unable to personally consent to treatment:

Client Name: _____

Name of Father: _____

Name of Mother: _____

Guardian (if not parent): _____

Managing Conservator (if not parent): _____

Status of Custody (circle or check as situation applies):

_____ Client is under full custody of biological or adoptive parents.

_____ Client is under joint custody of divorced parents, and I (we) are submitting court documentation to this agency. _____ (staff initials)

_____ Client is under full custody of one parent and only one parent _____(name) has full rights to seek psychiatric care and treatment.

_____ Client is in kinship or foster care and _____ (name) is the guardian of the child, able to seek psychiatric care and treatment. I (we) are submitting paperwork to this agency as evidence of the above. _____ (staff initials)

_____ Client is living with a non-parental relative but not under government conservatorship. I (we) are submitting paperwork to this agency. _____ (staff initials)

I understand that I must provide paperwork to this agency at time of visit for the minor client to be seen by a provider if the client is not under full custody of biological or adoptive parents.

Name of person giving consent for treatment: _____

Relationship to client: _____

Signature: _____Date: _____