Ascension Michigan
Behavioral Health

Patient Name:_____

Record Number:_____

BEHAVIORAL HEALTH OUTPATIENT AND TELEHEALTH GENERAL CONSENT TO TREATMENT

Consent to Treat

1. I voluntarily consent to treatment as recommended and fully explained to me by my behavioral health clinician.
2. I authorize and request my behavioral health clinician to develop and implement treatment plans or perform assessments with me and for me. I understand that the purpose of the assessment, my treatment plan goals, objectives and interventions will be discussed and explained to me as part of my treatment planning/assessment. I understand that my participation in my treatment/assessment is voluntary and that I can withdraw my consent and discontinue treatment at any time.
3. I understand that while the treatment plan is designed to be helpful, my behavioral health clinician can make no guarantees about the outcome of my treatment.
4. I understand that I am to follow through to the best of my ability in developing and achieving treatment goals and objectives, as agreed upon by my behavioral health clinician and me. I understand that if I fail to follow through on significant parts of my treatment plan, possibly resulting in harm to myself or others, my behavioral health clinician may choose to refer me to a more appropriate treatment setting.
5. I understand that I must be in active counseling with a behavioral health clinician in order to be seen by the psychiatric medical staff for medications, unless otherwise specified by plan.
6. I acknowledge that any violent or hostile behavior will result in discharge. I understand that possession of a weapon on clinic property is prohibited. I understand that I will be refused a therapy appointment on any day that I come to my appointment intoxicated. I understand and have been advised of additional program policies regarding conditions under which I may be discharged. I further understand that I have the right to appeal this action to the Clinic Manager within 15 days of when it occurs.
7. I understand that unauthorized photography, audio and/or visual recording are prohibited on the premises.
8. I understand that I have the right to speak to the Clinic Manager or Program Recipient Rights Advisor at any time I feel my rights have been violated.

Teaching Institution

I have been informed and understand that this facility is affiliated with a teaching institution and the therapy provided may require observation, cooperation and services of multiple behavioral health clinicians. I authorize residents and/or students to participate in my care.

Patient Financial Responsibility

1. The insurance information I have provided is accurate and complete.
2. I understand that it is my responsibility to check with my insurance provider and to understand what services are covered.
3. I accept the responsibility for fees, co-pays, deductibles and changes in insurance for all services rendered to me.
4. I understand that I am responsible for the cost of my treatment, and that I will be billed directly if insurance claims are rejected or denied.
5. I understand that established appointments are reserved for me and that I may be subject to the usual and customary charge for late arrival and all appointments missed or canceled without 24-hour notice.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

Name of Patient
(print) _____

Date:_____/_____/_____ Time:_____ Patient Signature:_____

Date:_____/_____/_____ Time:_____ Parent / Guardian Signature: _____

If a patient is unable to sign due to impairment (visual, physical or literacy), then the associate must sign the form here, as indicated, noting the date and time.

Date:_____/_____/_____Time: _____Associate Signature: _____

Ascension Michigan
Behavioral Health

Acknowledgment of Privacy Practices

The Ascension Michigan Notice of Privacy Practices provide information about how protected health information about me (the patient) may be used and disclosed. I understand that the terms of the Notice of Privacy Practices may change and that I may obtain a current copy by accessing the Ascension Michigan website at ascension.org/michigan or by contacting the Privacy Officer listed in the Notice of Privacy Practices.

Consent to Release Information

1. I authorize my behavioral health clinician to release information to my insurance provider that is required for the purpose of receiving reimbursement for services provided to me.
2. I consent to having information regarding my substance use disorder treatment documented in my Patient Health Record on paper or electronically, which can be viewed by other health care professionals as authorized. The purpose of this disclosure is to ensure safe and quality care.

Patient Rights and Responsibilities

I understand that I have rights as a recipient of outpatient behavioral health services. I have been offered a description of my rights and understand that I may receive additional information about my rights from the Recipient Rights Advisor.

Substance Use Disorder Treatment Patients

- ☐ I was offered a copy of the Know Your Rights Pamphlet _____ (Patient Initials)

Medicaid, Grant & Healthy Michigan Plan Patients

- ☐ I was offered a copy of the Grievance, Appeals & Fair Hearing documents _____ (Patient Initials)
- ☐ I was offered a copy of the Members Services Handbook _____ (Patient Initials)

Telehealth Services

- ☐ I consent to receive services through a virtual visit conducted using secure real-time audio and video _____ (Patient Initials)

☐ **For Ascension Genesys Hillside Behavioral Health Center ONLY**: I understand that the clinical practitioners (e.g. psychiatrists, social workers, psychologists, and counselors) are independent providers and are not employees of Hillside Center or Ascension Genesys Hospital. Hillside Center provides administrative and support services (i.e. scheduling and billing, medical records, office space) to the clinical practitioners. _____(Patient Initials)

I acknowledge that I have been offered the Ascension Michigan Notice of Privacy Practices and Patient Rights Materials that are specific to my care and treatment.

Date:_____/_____/_____ Time:_____ Patient Signature:_____

Date:_____/_____/_____ Time:_____ Parent / Guardian Signature: _____

If a patient is unable to sign due to impairment (visual, physical or literacy), then the associate must sign the form here, as indicated, noting the date and time.

Date:_____/_____/_____ Time:_____ Associate Signature: _____