Form 114a Consent to Use Protected Health Information

NORTHERN PINES MENTAL HEALTH CENTER TREATMENT CONSENT FORM

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 chemical dependency treatment; and although mental health and/or chemical dependency treatment helps many individuals, it is not always completely effective. I hereby give written consent for mental health/chemical dependency 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

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 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. 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.

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 to remind you of an appointment? (This does not guarantee a reminder call.) **It is either all appointment reminders or no appointment reminders, we are unable to differentiate text messaging between the different programs**

____No ____Yes If yes, telephone number to call: _____

7. 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.

8. This Treatment Consent will expire in one year from the date I sign or unless I request an earlier expiration in writing.

_____

Client's Printed Name

_____ _____

Client's Signature Date

_____

Witness

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 agree to pay for all services provided to my minor child including all charges not covered by insurance. 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.

Child's Name: _____ Birthdate: _____ / _____ / _____

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____ Date: _____

Witness: _____

ALCOHOL AND/OR DRUG ABUSE CONSENT FOR TREATMENT

No information regarding Alcohol and/or Drug Abuse treatment will be provided **unless you** authorize by initialing:

_____ Release Alcohol and/or Drug information.

As a SUDS Client I understand this release ☐ is ☐ is **not** 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.

1. My health information is protected by federal regulation (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and/or HIPAA 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in Northern Pines Mental Health's Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws.
2. For disclosures other than for treatment, payment and healthcare operations purposes, treatment may not be conditioned on my agreement to sign and authorization (unless I am receiving care solely to create protected health information for disclosure to a third party) (45 CFR §164.508 (b)(4)(III)
3. Federal confidentiality regulations (at 42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Northern Pines Mental Health to notify me of the potential that information disclosed pursuant to this Treatment Consent might be re-disclosed by the recipient and is no longer protected by HIPAA rules.
4. **This Treatment Consent will expire in one year from the date I sign or unless I request an earlier expiration in writing.**

_____

Client's Printed Name

_____ _____

Client's Signature Date

_____

Witness