# Consent for Treatment

**Client:** _____

## Consent

_____ (the "Patient" or the "Legal Representative or Agent of the Patient") by signing this three-page form:

1. I apply for and consent to such medical or psychiatric care, including counseling by non-physician professional staff of Meridian Behavioral Healthcare, Inc. ("Meridian") which care may include prescription of medications, diagnostic tests and in-patient and out-patient care and treatment for me or for the minor child or other person for which the legal representative or agent is signing;

2. I consent to the use or disclosure of any Protected Health Information ("PHI") by Meridian for the purpose of medical or psychiatric care, for the purpose of counseling or for the payment for services provided by Meridian in accordance with all state and federal privacy laws as described in the Notice of Privacy Practice which has been furnished to me;

3. I understand that any alcohol or drug treatment records are protected under specific Federal regulations governing confidentiality of alcohol and drug abuse patient records which records cannot be disclosed without my written consent unless disclosure is otherwise provided for in Federal regulations;

4. I understand that all of my records with Meridian are protected under the Federal Privacy Regulations within the Health Insurance Portability and Accountability Act ("HIPAA") and under the Health Information Technology for Economic and Clinical Health ("HITECH");

   4.a. In addition, I understand that I may be asked to release information to myHealthStory for the purpose of receiving healthcare and the coordination of my care by my Providers. Should I wish to receive this coordination of care, I understand a special Health Information Exchange Release will be provided to me so that I may authorize Meridian to share my information with my other Providers.

5. The recipient of such information which is disclosed may re-disclose the information and it may no longer be protected by the privacy laws.

6. I consent to receive a follow-up call for up to 18 months after completion of any treatment by Meridian.

## Payment For Services

By signing this form, I express my understanding that I am obligated to pay for all services provided by Meridian which are not paid for by any available insurance benefits which may aid in the payment for services. I acknowledge that if I lose insurance eligibility or if coverage is denied or reach benefit maximum, I am fully responsible for all of the fees charged by Meridian.

1. I am responsible for any deductible and any co-pays based on the specific insurance plan;
2. If insurance that provides coverage for me is not available for care by Meridian, it is my responsibility to verify what services by Meridian will be covered and obtain authorization for those services. I accept that I am responsible for any charges not covered by insurance;
3. I agree to contact Meridian and provide notice to Meridian at least 24 hours in advance of any cancellation of appointment or my being unavailable to keep an appointment. I understand that if such notice is not furnished, a charge of $25.00 for a missed appointment will be assessed;
4. I understand that if I am a MEDICAID recipient, I am responsible to pay a maximum of a $2.00 co-pay based on the specific MEDICAID plan, my age or any disability status;
5. I understand that if I am a participant in MEDICAID SHARE OF COST, then I will be charged an assessed fee until becoming eligible for MEDICAID coverage in any given month at which time Meridian will bill MEDICAID for services. All services received before becoming eligible for MEDICAID are my responsibility. I understand that it is my responsibility to provide proof of expenses to the local MEDICAID/DCF Office each month;
6. If I am a MEDICARE beneficiary, I am responsible for all deductibles and co-pays as set by MEDICARE. MEDICARE fees are subject to change based on my individual coverage or changes in the MEDICARE policy. Physicians, nurses and other therapists at Meridian who are enrolled as MEDICARE Providers accept assignment (which means I pay the co-pay and Meridian bills MEDICARE as payment in full). I understand that some Meridian therapists are not enrolled as

MEDICARE providers. If I choose to receive clinical services from a provider who is not enrolled as a MEDICARE provider, I am responsible for the fees charged.

7. I understand that if I am eligible for self-pay/sliding fee scale which Meridian offers to uninsured individuals, that my fee will be based on my income and family size. Additional discounts may be offered to me if I can document a situation of financial hardship. Discounts based on hardship are evaluated on a case-by-case basis.

**Family Income Information**

**TOTAL in HOUSEHOLD #**
**List ALL Household Family Members**

| Last Name | First Name | DOB | Age | Relationship to Client |
|---|---|---|---|---|
| | | | | **Client** |
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| Source of Income | Annual Amount | Last 30 Days |
|---|---|---|
| Employment Income | $ | $ |
| Social Security Income | $ | $ |
| State AID- SSI, AFDC, Medicaid | $ | $ |
| Food Stamps | $ | $ |
| Pension Income | $ | $ |
| Workers Comp Income | $ | $ |
| Unemployment Income | $ | $ |
| Child Support/Alimony | $ | $ |
| Money from Family Member/Other | $ | $ |
| Other Income | $ | $ |
| **TOTAL Annual** | $ | ---------- |
| **TOTAL Last 30 Days** | ---------- | $ |

| |
|---|
| County of Residence: |
| Third party / COBRA assistance - If unemployed and you were previously covered by Health insurance? Yes ☐ or No ☐ |
| Date of last worked day |
| Have you applied for Medicaid or county assistance? Yes ☐ or No ☐ If yes, when and where? |
| Have you applied for WIC/food stamps? Yes ☐ or No ☐ If yes, when and where? |
| Have you applied for social security disability (SSI/SSD)? Yes ☐ or No ☐ If yes, when and where? |

# Consent for Treatment

**Client:** _____

| INSURANCE BENEFIT DETERMINATION AND ESTIMATED OUT-OF-POCKET EXPENSE | | | | |
|---|---|---|---|---|
| **Service Location** | **Substance Abuse Benefits** | **Mental Health Benefits** | **Deductible/Coinsurance** | **Copayment** |
| Inpatient | | | | |
| Outpatient | | | | |
| Intensive Outpatient | | | | |

**Questions About Billing, Charges Or Fees**

If I have any questions about the requirements or payment for services or the fee determination of the insurance benefits determination, I can call the Meridian Finance and Accounting Department which is available to assist me with any questions or information during regular business hours by calling: 352-374-5600, Extension 8323.

**Authorization For Insurance Billing**

A Financial Counselor or other knowledgeable person with Meridian has explained any insurance benefits that are available to me. I authorize Meridian to contact any insurance company with which I may have benefits to obtain an explanation of my benefits. I understand that I am responsible for charges not paid by any available insurance coverage or available benefits from MEDICARE. I understand it is my responsibility to pay any out-of-pocket expenses in full or make arrangements for payments before discharge. Any arrangement for payment will be through a promissory note or other financial document. In addition to authorizing insurance billing, I understand and accept responsibility that Meridian may exercise its rights to collect from me all charges I owe and whatever amount for which I have provided a promissory note. I recognize that there may be collection charges and legal fees for collection efforts.

**Termination of Care for Non-Payment**

By signing this Professional Services Agreement, I acknowledge that Meridian has the right to terminate treatment and refer me elsewhere for continuing care if I have an unpaid balance with Meridian exceeding $500. I understand that I may be allowed to defer payment for a maximum of two out-patient sessions after which no further services will be provided. Unless prior arrangements have been made, I understand that treatment may be terminated at any time if payments have not been made as agreed. Any such termination will be consistent with requirements governing various therapists who may provide care.

**Termination of Care for Missed Appointments**

By signing this Professional Services Agreement, I acknowledge that should I fail to keep two consecutive appointments within a 30-day period, a scheduling lock will be placed on my account and I can be discharged from Meridian programs. I also understand that in order to resume services, I must contact the Program Director (of the Program I want to resume) and request readmission.

| | |
|---|---|
| **Signature of Patient or Legal Representative or Agent of Patient** | |
| **Description of the Kind of Representative or Agency Status (Parent, Legal Guardian, Next of Kin, Health Care Surrogate)** | |
| **Witness to Signature of Patient or Legal Representative or Agent** | |