General/Informed Consent, Authorization to treat and Financial Agreement

In order for Cambia Hills East Bethel to treat you, please sign below indicating your consent to treatment:

A. I give my consent to Cambia Hills East Bethel mental health practitioners and healthcare workers to perform exams, tests and assessments, provide treatment, administer immunizations, and give me over the counter (see the Over The Counter Medication Information Form at the back of this packet for more information) or prescription medicine that has been prescribed for me that they believe are necessary or helpful to my health.

B. I understand that while I am receiving care, a Cambia Hills East Bethel employee may accidently be exposed to my blood or other body fluid. If this rare event occurs, I consent to have my blood tested for blood-borne pathogens, such as Hepatitis B and C, and HIV. I understand that the test results will become part of my medical record and will be released to the exposed individual and a positive result must be reported to the state by law.

C. I authorize payment from Medicare, Medicaid, insurance, and any other funds to be paid directly to Cambia Hills East Bethel for my care and treatment. I understand that it is my responsibility to comply with the requirements of my insurance policies.

D. I agree to pay any charges not covered by insurance, government programs (including Medical Assistance), or other funds for healthcare services provided by Cambia Hills East Bethel.

E. A copy of the Patient Bill of Rights, information on Healthcare Directives, and information about how to file a complaint has been given to me.

F. If applicable, I request that payment of authorized Medicare benefits be made on my behalf to Cambia Hills East Bethel for any services furnished me by a Cambia Hills East Bethel provider and/or in a Cambia Hills East Bethel facility. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

G. I give consent for evaluation and treatment to be provided for myself/my child by Cambia Hills East Bethel.

H. I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

I. The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

J. I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

K. I agree that there may be certain circumstances in which the provision of my child's mental health services may be via telemedicine. I understand that the video and audio connections used for telemedicine are secure and meet federal, state, and agency privacy standards. I understand that my participation in telemedicine is voluntary.

L. I understand that I may terminate treatment at any time.

Cambia Hills East Bethel respects your right to privacy. Under the following conditions your health information will only be released with your consent:

A. I authorize Cambia Hills East Bethel to release my medical records to and, as needed, to discuss my care with my doctors, other healthcare providers, and anyone else Cambia Hills East Bethel either believes to be involved in, or who may participate in my care, treatment, case management, and or/discharge planning. This includes source documents (such as x-rays). I authorize Cambia Hills East Bethel to electronically release my protected health information to other healthcare providers involved in my care and treatment and who share electronic medical record systems with Cambia Hills East Bethel. This includes information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, and developmental disabilities.

B. To improve the coordination of my care, I authorize Cambia Hills East Bethel to electronically release my protected health information to other healthcare providers involved in my care and treatment and who participate in local, state, and/or national Health Information Exchanges. This may include information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, and development disabilities

C. I authorize Cambia Hills East Bethel to release my protected health information to insurance companies, government programs, and other parties who are responsible for, or who facilitate, payment of my bill, fraud investigation, care management, or quality improvement. This includes behavioral health and chemical dependency information. I also authorize Cambia Hills East Bethel to release my protected health information to e-Prescribing networks to facilitate prescription management.

D. I authorize Cambia Hills East Bethel to release information from my medical records to emergency service providers involved in my care.

E. I authorize Cambia Hills East Bethel to release information from my medical records and source date as needed to accrediting organizations and to legally authorized agencies to oversee healthcare activities and to specialty boards for board certification/recertification of healthcare practitioners.

F. I authorize Cambia Hills East Bethel to discuss bill or payment issues with an adult household member who gives my name, address, date of birth, and either my account number or insurance ID number as well as their own name and address.

G. I authorize Cambia Hills East Bethel to disclose my presence and religious preference to Cambia Hills East Bethel chaplains and to clergy of my denomination, and to disclose my presence to foundations that support Cambia Hills East Bethel and its mission. I understand that Cambia Hills East Bethel will ask specific permission before disclosing my presence to behavioral health or chemical dependency services.

H. I agree to the presence of staff, observers from other healthcare facilities, healthcare consultants, and approved representatives of medical service providers during treatment and other services at Cambia Hills East Bethel.

I. I understand that Cambia Hills East Bethel will also seek my oral permission to have non-Cambia Hills East Bethel persons present during any services.

J. I authorize my health insurance plan to release to Cambia Hills East Bethel my protected health information about services I have received from Cambia Hills East Bethel and other care providers unrelated to Cambia Hills East Bethel. Cambia Hills East Bethel may use this information for treatment, payment, operations, and case management purposes.

K. I understand that this authorization ends (1) year from the date signed except for purposes of payment and research.

L. If this is the first time I have received medical/behavioral health services from Cambia Hills East Bethel, I acknowledge that a copy of the current Notice of Privacy Practices has been provided to me and is available to me via postings in the registration areas and on the website www.thehillsyfs.org.

Cambia Hills East Bethel would like you to be aware of the following financial policies and agreements

A. YOUR INSURANCE We will file your claim with your insurance company as a courtesy to you. For people covered by more than one policy, we also file claims to the "secondary" insurance. To allow for filing of your insurance benefits, please bring your insurance card upon admission as well as at any time your insurance coverage changes. As insurance carriers may change frequently, it is the policyholder's responsibility to determine whether or not we are contracted providers with your insurance company before being seen.

- Please be aware that few insurance companies cover all medical costs. You may be responsible for co-payments, co-insurance, or deductibles. You are responsible for payment regardless of any insurance company's determination of usual and customary rates that may bear no relationship to the current standard and cost of care in this area. If there are any disputes with your insurance carrier regarding your policy guidelines and insurance payments, it is important that you be involved to insure that you receive the full benefit due you. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge.
- Insurance policies vary widely in how they pay for mental health services. Often pre-authorizations are required for a specific number of visits. In some cases, an initial referral from a primary care doctor is needed. Depending on your policy, your involvement may be critical for some steps in the process, such as obtaining an initial referral. Your doctor or therapist can explain the reasons for the different kind of charges used, such as evaluations, individual therapy, or family therapy.
- A treatment deposit may be required prior to admission. If a deposit is required our business office will review the specific requirements with you and provide you with details.
- For specific billing questions please contact our business office at EastBethelBilling@cambiahills.org or by phone at 218-623-6454.
- I authorize Cambia Hills East Bethel to contact my primary care physician / Managed Care Network on my behalf to request a referral that may result in coverage at the "in Network" benefit level.
- Authorization for release of information to Insurance Companies: By signing this document below, you are authorizing Cambia Hills East Bethel release medical information to your insurance company, including governmental payers such as Medicare, Medical Assistance and Worker's Compensation as required or permitted by law. This includes but may not be limited to confidential medical information which may include drug/alcohol abuse, HIV status, or psychiatric treatment as necessary for payment of claims. This may include verbal, written or faxed information.
- If you would like to Request a nondisclosure to Insurance Companies please initial on the line below

B. METHODS OF PAYMENT: We accept cash, check, VISA, Discover, American Express and MasterCard. We do not accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made in advance of your appointment as necessary.

C. INFORMATION CHANGES: Be sure to advise us of any address or phone number changes. We cannot be responsible for delinquent accounts due to lack of receipt of statements or other correspondence if we do not have a current or correct address or phone number on file.

D. COLLECTION PROCEDURES: A Billing Representative is available to help with payment arrangements from 8:00am to 4:30pm Monday through Friday. We have a Community Care Program available for those patients who qualify. Once made

in writing, agreements are binding. Failure to respond to communications from our office may result in termination of treatment and/or involvement of an outside collection agency. You will be responsible for any fees or interest charged in association with collection of your account.

E. ASSIGNMENT OF BENEFITS: If you have health care insurance or are entitled to benefits under any private or government health plan or policy, you agree that Cambia Hills East Bethel may bill these payers and they may make their payments directly to Cambia Hills East Bethel. Your signature on this form is your authorized signature for the filing of a claim and request for direct payment of benefits by any payer to Cambia Hills East Bethel.

F. I have read and understand this financial policy of Cambia Hills East Bethel and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time.

- I understand that I may revoke this permission at any time by notifying Cambia Hills East Bethel in writing. No further release will take place after the date notified.
- I understand that other parties may use or disclose health information received from Cambia Hills East Bethel.
- I have been given the opportunity to review Resident Rights and Responsibilities and know that a copy of this is available by request at any time.
- I understand I may request a copy of this form or any form referenced herein at any time.
- I have been given the opportunity to review this form and ask any related questions.
- _____ I am a self-pay patient and will pre-pay for the service(s) I receive in full. By initialing here I request that Cambia Hills East Bethel not disclose my treatment information to my insurance company. **NOTE: 90 day prepayment of the per diem will be due at time of admission for all self-payment individuals.**
    - Additional payments will be collected each month past the initial 90 days for the per diem on self-pay individuals.

If I am signing as Authorized Representative of the patient, I am:

☐ Parent of a minor ☐ Court appointed guardian/conservator ☐ Other: _____
(Please specify relationship to patient)

_____ _____ _____
Signature (Patient or Authorized Representative) Date Time