Lake County Health Department
and Community Health Center
Behavioral Health Services

CLIENT CONSENT FOR TREATMENT AND PAYMENT

Rev. 02-13 (C) (H)

I, _____________________________ consent to admission and treatment by the physicians and staff of the Lake County Health Department and Community Health Center's Behavioral Health Services programs. I consent to participate and to work with staff to develop a treatment plan appropriate to my treatment needs and goals.

I recognize that an illness or an emergency may require prompt medical attention. I hereby consent that, if I am unable to participate in making this decision, such medical attention be given by this facility or by transfer to another facility at the sole discretion of the physician, program director or nurse in charge, and release them from all liability for so doing.

I understand that Behavioral Health Services programs do not discriminate against persons with AIDS related medical conditions or on the basis of HIV antibody status. Therefore, I understand that such individuals may be admitted to treatment. The Behavioral Health Services programs have instituted procedures to avoid possible risks of disease transmission. I agree to adhere to all facility policies for which I am responsible.

The nature, purpose, risks and benefits of the treatment and possible alternatives have been explained to me. If any risks are involved, a staff member will explain these to me. I have received a copy of my client handbook, and have been informed of my rights and responsibilities.

Family involvement may be helpful in your treatment. Please check one of the following:

___ I agree to involve my family/significant other in my treatment. (Authorization for Release of Information is required)

___ I do not want my family/significant other involved in my treatment.

I, the undersigned, also give my consent to the Behavioral Health Services' programs to release all information necessary, including my name, date of birth and Social Security Number (SSN), family income and number of dependents, to the Illinois Department of Human Services (IDHS)and the Illinois Department of Healthcare and Family Services, in order to establish my eligibility for funding for my treatment. I understand that the release of my Social Security Number is voluntary. Failure to provide my SSN may jeopardize funding for my treatment from state agencies, and may make me responsible for payment for treatment. If I am required to provide toxicology testing as part of my care, I understand that my SSN will be used to report the results to IDHS. See "Client Rights" for confidentiality regulations.

Signature of Parent/Guardian required if client is less than 18 years old or requires guardianship. If client is at least 12 years of age or less than 18 years of age, signatures must be obtained from client and the parent or guardian (for Mental Health Services only).

AUTHORIZATION FOR RELEASE OF INFORMATION FOR PAYMENT

Services will be billed to Medicaid, Medicare or other third party payer. We do charge a usual and customary fee for services. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Your insurance policy is a contract between you and your insurance company. No one will be refused services because of an inability to pay.

I authorize the Lake County Health Department and Community Health Services to release and/or send any medical information necessary for the processing and payment of my medical bills to any insurance company or third party payer who may be responsible for paying any part of my medical treatment. This includes release to my employer for employment related injuries under a worker's compensation claim. We will make every effort to ensure confidentiality in all transactions.

I have read and had the opportunity to ask questions and agree to the conditions stated above.

Signature: ____ Date: ______________________

Relationship to patient: ☐ Self ☐ Parent/guardian

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

As a client of the Lake County Heath Department and Community Health Center, I have been provided with its Notice of Privacy Practices, which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights. I acknowledge that I have received the Notice of Privacy Practices and understand how medical information about me may be used, the duties of the Lake County Health Department and my rights to privacy protection and access to my medical information. I understand that the Privacy Officer is available to answer any questions that I may have regarding issues of privacy.

I also acknowledge that this Notice of Privacy Practices is not a contract between the Lake County Health Department and Community Health Center and the undersigned, but merely a notice of my privacy rights under state and federal law.

NOTICE FOR CLINICIAN: In witnessing this consent, I verify that I have explained the client's rights and believe that the client understands these rights.

____ ____

Client Signature Date Witness Date

____

Parent/Guardian Signature Date

CLIENT NAME: ____ I.D.: ____________________

Original to Client Chart/ Copy to Client