FOUNDATIONS BEHAVIORAL HEALTH SERVICES, INC.
CONSENT FOR TREATMENT AND FINANCIAL AUTHORIZATION FOR SERVICES

Client Name: _____ **Date of Birth:** _____

CONSENT FOR TREATMENT

I, the undersigned, am the client/patient (or the client's duly authorized representative) and do hereby voluntarily CONSENT to and AUTHORIZE behavioral health services from Foundations Behavioral Health Services, Inc. (Foundations) as are required to meet my treatment needs.

I further understand that I have the right to refuse treatment or to withdraw this consent for treatment at any time. At such time that a client refuses treatment or withdraws consent for treatment, attempts will be made to ensure that the client understands the implications and potential consequences of refusal or withdraw from treatment, and to develop alternative treatment approaches with the client when possible and appropriate.

This agreement also will serve as the basis for determination of who is responsible for payment for services provided by Foundations to the client/patient. I understand that all information will be kept confidential consistent with Federal and State laws.

Signature of client/patient or legal representative or agent _____ Date _____

VERIFICATION OF CLIENT RIGHTS & RESPONSIBILITIES AND PRIVACY NOTICE

My initials indicate I have received a copy of the following notices:

_____ Client Handbook _____ Notice of Privacy Practices

The above information was reviewed with me by the staff of Foundations and I was given an opportunity to ask questions. I understand I can have these booklets read to me if I am unable to read them myself. My signature below indicates my understanding of the materials given to me.

Signature of client/patient or legal representative or agent _____ Date _____

RELEASE OF INFORMATION FOR PAYMENT

I understand my insurance company may need to know about me and the care I receive before it will pay my bill. I AUTHORIZE Foundations to give any information about the treatment I received from Foundations to my insurance company or other Payer for my visits to determine whether they are liable to pay my bill.

I understand I may be eligible to receive services that are paid in full or part by public funds. I AUTHORIZE Foundations to disclose to the local Alcohol, Drug Addiction, and Mental Health Services Board (ADAMHS Tri-County Board of Mercer, Paulding and Van Wert counties) and the Ohio Department of Mental Health and Addiction Services (ODMHAS), and the Ohio Department of Job and Family Services (ODJFS) information required to enroll me in the Tri-County Board Behavioral Health Service Plan through the SmartCare Information System, to determine my eligibility for public funds and pay Foundations for services.

The purpose of the disclosure authorized herein is to enroll me in the Tri-County Health Services Plan through the SmartCare software to determine my eligibility for public funds and pay Foundations for services. I also understand that failure to sign the disclosure statement, the Tri-County Board may not be able to use public funds to pay for my services.

I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 23, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Name-identifying information will be used only to pay for services provided to you. Other information will be reported, without your name attached, to ODMHAS, ODJFS and the Ohio Health Data Center (which is required by law to collect such information.) Information will not be available to other state departments, public or private organizations. Name-identifying billing information will be kept for up to seven (7) years after you have received services, and only other non-name-identifying after that time.

Signature of client/patient or legal representative or agent _____ Date _____