CONSENT FOR TREATMENT, CONFIDENTIALITY AGREEMENT AND ASSIGNMENT OF BENEFITS

Behavioral Health & Substance Abuse Network, Inc.
(BHSAN)

Patient Name _____ **Date of Birth** _____

Please initial after each section to indicate your understanding and acceptance of the contents of the section. Please sign and date on the bottom, Thank You.

CONSENT FOR TREATMENT

I have been informed about the procedures in which I and/or my child (ren) will participate at Behavioral Health & Substance Abuse Network, Inc. (BHSAN), including length of treatment, confidentiality and exceptions to confidentiality, and nature of the treatment or other procedures. These procedures may include individual, group or family psychotherapy or counseling, traditional counseling and psychological testing. I am giving consent to my voluntary participation in therapeutic groups run by a counselor from Behavioral Health & Substance Abuse Network, Inc. of that if a part of my treatment plan. I understand that what is shared in group must be kept confidential. It must not be shared outside the group with anyone unless the group as a whole gives permission. I understand that I may decline further participation at any time. I agree that no promises have been made to me as to the results of treatment or of any procedures. I understand that my treatment provider may have to consult with other members of my family or consult with other specialists concerning my treatment. ***Initial here:*** _____

LIMITS OF CONFIDENTIALITY

I understand that all information regarding this work will remain confidential and will not be shared with others outside Behavioral Health & Substance Abuse Network, Inc. (BHSAN) and other interagency approved persons or agencies without my consent. I understand that my counselor may receive supervision for my case and may need to discuss information about my case with the supervisor. I also understand that there are conditions under which this confidentiality must be broken and information be shared with the appropriate individuals. These conditions are as follows: a. If there is suspicion that a child is being abused; b. If there is evidence of physical abuse of elder or dependent adult; c. If I am making serious physical threats against others or myself. I understand that in cases of medical emergency, information sufficient to resolve the situation may be disclosed to emergency personnel, and I will be informed of this disclosure as soon as feasible.
Initial here: _____

I understand that Behavioral Health & Substance Abuse Network, Inc. is committed to protecting my health information and that they follow the HIPAA guidelines for disclosing and protecting my PHI (private health information). I understand that a full copy of the HIPAA rules and regulations will be provided to me upon my request. ***Initial here:*** _____

This form shall be applicable to all providers I or my child(ren) may use at Behavioral Health & Substance Abuse Network, Inc.

FINANCIAL AGREEMENT

I assign payment of all insurance benefits under all existing insurance policies to Behavioral Health & Substance Abuse Network, Inc. (BHSAN), including funds payable to an attorney involved in the claim (if applicable). In the event that services are provided and are not covered by my insurance plans, I will be responsible for payment for these services. I understand that The Pathfinder Project submits claims directly to my insurance company on my behalf. I understand that **I AM RESPONSIBLE TO INSURE THAT CLAIMS ARE PAID BY MY INSURANCE COMPANY**. ***Initial here:*** _____

I understand that my co-payment, coinsurance and or deductibles are due at the time services are rendered. I understand that my insurance plans may have certain limitations on mental health benefits in the form of pre-certification, number of visits allowed or dollar amount per policy year as well as lifetime maximum benefits. I agree to accept full responsibility for charges once limitations have been reached. At any time during treatment, should I or my child(ren) become ineligible for insurance coverage, I will notify Behavioral Health & Substance Abuse Network, Inc. and understand that I will become responsible for 100% of the bill.
Initial here: _____

I understand that, either late cancellation (less than 24 hours notice prior to the appointment time) or a "No Show" to a scheduled appointment will result in my being charged a $50.00 fee, due and payable before my next scheduled appointment. Exceptions will be given in cases of extreme emergencies or inclement weather.
Your insurance plan does not pay for this fee. ***Initial here:*** _____

I understand that I am financially responsible for all charges whether or not paid by said insurance. Unless specific arrangements are made in advance a delinquent account (over 60 days past due) will result in my account being turned over to collections. If referred to collections, Behavioral Health & Substance Abuse Network, Inc. reserves the right to charge a 30% collection fee. If I pay for services with a personal check, I understand that I will be charged a $25.00 returned check fee, if my check is returned by my financial institution/bank. ***Initial here:*** _____

ASSIGNMENT OF BENEFITS

I authorize Behavioral Health & Substance Abuse Network, Inc. (BHSAN) to release any or all information pertinent to my treatment to my insurance companies for reimbursement and I hereby assign payment directly to Behavioral Health & Substance Abuse Network, Inc.

_____ _____
Signature of Patient/Parent or Guardian if Minor Child Date

*To Medicare Patients, this applies to the Social Security Administration or its intermediaries or carriers.