SEVEN HILLS HOSPITAL

Place patient label here

Patient Name: _____

Consent for Treatment

Name of client: _____ Date of Birth: _____

I, _____, authorize Seven Hills Hospital to provide mental health services for myself or for the above named individual. If the individual named above is a minor or an adult who has been adjudicated legally incompetent, I certify that I am the legal guardian of such person and have the legal right to approve of such services.

I understand that most information disclosed to Seven Hills Hospital is protected by federal, state and local laws and regulations governing confidentiality. As such, I understand that much information cannot be disclosed to others without my written authorization, except under limited circumstances.

I understand that during the course of receiving services, Seven Hills Hospital received, originates, maintains, discloses and uses individually identifiable protected health information (PHI), including but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatments, treatment plans and billing / health insurance information.

I understand that Seven Hills Hospital and its employees and contractors, including physicians, therapists, social workers, interns, other health care professionals and administrative staff may use my PHI to perform the following tasks:

- Diagnose my medical, psychiatric, or psychological condition
- Plan my care and treatment
- Communicate with other health care professionals concerning my care
- Document the services I receive in order to obtain payment or reimbursement; and,
- Conduct routine health care operations related to Seven Hills Hospital's business, including quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel)

I understand that I do not have to consent to the use or disclosure of my PHI for treatment, payment and health care operations. However, I also understand that if I do not consent, Seven Hills Hospital may refuse to provide me with treatment unless required by federal or state law.

I understand that I have the right to request restrictions on the use or disclosure of my PHI to carry out treatment, payment or health care operations, though Seven Hills Hospital is not obligated to agree to the restrictions. To request such a restriction, I understand that I must place the request in writing and deliver it to Seven Hills Hospital. Seven Hills Hospital will review each request to determine if the restriction is agreeable and permitted by law.

I understand that I may revoke this consent in writing by delivering to Seven Hills Hospital a written notice of revocation. I understand that the revocation will not be effective to the extent that Seven Hills Hospital has already taken action in reliance on my earlier effective consent.

I understand that there are legal expectations, in which my consent is not necessary to disclose PHI or similar information to others, including;

- In cases of past or present suspected child abuse or neglect, a report must be made to Child Protective Services
- In cases of abuse or neglect of 1) an individual older than age 60; or 2) a disabled individual; or 3) individuals adjudicated legally incompetent, a report must be made to local law enforcement agencies.
- For cases in which a client is in imminent risk of harming himself / herself or others, or when an individual with mental illness needs hospitalization, confidentiality may be suspended in order to protect the client or others, and to treat the mental illness.
- If a client appears to have been injured by a knife, firearm, or burn, such information must be reported to the applicable local law enforcement or local fire department agencies.
- Confidential information may also be disclosed when required by a valid court order or subpoena signed by a judge or magistrate, including but not limited to, cases in which a court orders a psychological evaluation.
- Seven Hills Hospital may share confidential information about a deceased individual to the executor of the deceased's estate, or if a client's mental health information is necessary to determine the validity of a will.
- For cases in which a client's confidential information is part of a government investigation or hearing, including but not limited to, investigations conducted by the Nevada Board of Medical Examiners

I understand that Seven Hills Hospital will provide the necessary staff for the purpose of treatment planning and management of the services I receive.

I do / do not ***(please circle one)*** authorize Seven Hills Hospital to leave phone messages, including voicemail and answering machine messages, about scheduling, canceling or confirming appointments.

I do / do not ***(please circle one)*** authorization someone else to be able to call Seven Hills Hospital to schedule, re-schedule, confirm or cancel appointments. I authorize _____ who is _____ (relationship to patient) to contact Seven Hills Hospital to schedule, re-schedule, confirm or cancel appointments on my behalf.

I understand that this authorization is only allowed for scheduling needs. No information regarding treatment or medical care will be provided to the identified individual. Should I choose to allow additional information to be given; I will have to complete the Authorization for Disclosure form.

I authorize Seven Hills Hospital to open an account under my name for insurance benefits to be paid to Seven Hills Hospital. I accept full financial responsibility for any payments not covered or paid for by insurance. Furthermore, I authorize Seven Hills Hospital to release my PHI, including my medical records

and any other information necessary to process any insurance claims or access employee benefits, including, but not limited to, my previous treatment history, mental health or substance abuse issues, and medical history.

I understand that if my account is in arrears, Seven Hills Hospital has the sole discretion to refuse providing me with future appointments. I also understand that if my account is not paid in full within a period of time acceptable to Seven Hills Hospital, a collection agency may be notified. I agree to pay all costs associated with the collection, as well as all attorneys' fees and court costs if a lawsuit is filed.

Please note that if Seven Hills Hospital is not contracted with your secondary insurance, then all co-pays/ deductibles co-insurances are due at the time of service. Seven Hills Hospital will provide a copy of the primary insurance explanation of benefits to you and /or guarantor.

I understand that if I do not show up for an appointment, or if I fail to cancel an appointment prior to 24 hours before my appointment time, Seven Hills Hospital may charge me a missed-appointment fee of $50.00. I understand that the missed-appointment fee will not be covered by insurance, and so it is my responsibility to pay.

I have read and understand all of the provisions of this Consent for Treatment. I agree to abide by all of my obligations contained in this Consent for Treatment.

_____ _____

Client Signature Date

_____ _____

Spouse if Conjoint Treatment Date

_____ _____

Legal Guardian Signature (if applicable) Date

_____ _____

Witness Signature Date