Behavioral Health Consent and Disclosure Agreements

Patient Name:____________________________**MRN:**__________________

Phone:__________________________________ **Date of Birth:**__________

Informed Consent for Treatment

Alliance Health provides integrated primary medical, behavioral health, and other health care services to meet your needs regardless of your age, gender, gender identity, color, race, ethnicity, creed, national origin, religion, disability, sexual orientation or veteran status. The purpose of that care is to:

- Obtain information through a history and assessment for diagnosis and developing a plan of care
- Treat disease, mental health, injury, and disability by testing, use of procedures, therapies, and medications
- Aid patients in achieving their maximum potential within their capabilities
- Accelerate patients/clients gradual return to health and strength after illness, and reduce the length of the functional recovery, however, this outcome is not guaranteed.

Referrals will be made to other agencies and providers that are appropriate to the needs of the patient. This may include a referral to other behavioral health services in the community.

As part of your integrated care, we use an electronic health record that includes your medical, behavioral health, and other health information. In order to give you the best care possible, all of your care team may view the complete record, including information related to AIDS, AIDS related complex, HIV, mental health, and substance use treatment. This authorization also pertains to the Federal Regulation 42 CFR Part 2 of the State Statues in regard to Mental Health, Alcohol, and Drug Abuse.

You will have the option of receiving treatment in the office or through the use of tele health visits. Telehealth involves the use of electronic communications including (1) live two-way audio and video; (2) interactive audio and messaging via telephone to enable healthcare providers at different locations to provide patient care and mental health services and therapy. Telehealth services offered by Alliance Health may also include chart review, appointment scheduling, health information sharing, and non- clinical services, such as patient education. The information you provide may be used for diagnosis, therapy, follow-up and/or patient education, and may include any combination of the following: (1) health records and test results; and (2) output data from medical devices and sound and video files.

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits of Telehealth:

- Improved access to care by enabling you to remain in your home.
- More efficient care evaluation and management.
- Obtaining expertise of a specialist as appropriate.

Possible Risks of Telehealth:

Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.

In rare events, our provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person consult.

In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

By signing below, you acknowledge that you understand and agree with the following:

1. I hereby consent to receiving Alliance Health services via telehealth technologies. I understand it is up to the provider to determine whether or not my specific clinical needs are appropriate for a telehealth encounter.

2. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Alliance Health will take steps to make sure that my health information is not seen by anyone who should not see it.

3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of Alliance Health. I agree to hold harmless Alliance Health for delays in evaluation or for information lost due to such technical failures.

4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1- 1 immediately and that Alliance Health providers are not able to directly connect me to local emergency services.

5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

The signature below at the bottom of this page provides Consent for Telehealth Treatment. I fully understand that this consent is given in advance of a specific diagnosis or treatment. I am also aware that this consent will remain in effect until revoked in writing. My consent will be carried over to other Alliance Health locations should I choose another provider or service within this organization.

Financial Agreement

I understand that Alliance Health will charge fees for the service rendered for my care. These fees may be estimated at times based on anticipated services to be provided, but will always be adjusted to the actual fees associated with the exact services that were provided to me. To ensure Alliance Health bills my insurance company correctly, I am responsible for providing Alliance Health with accurate insurance information.

If I have medical insurance, Alliance Health will bill my insurance company the fees referred to above. I acknowledge and understand that I am responsible to know what medical services my insurance company will cover or not. I also understand that I will be responsible to pay for the amount that my insurance company will not cover, which includes insurance co-pays and/or deductibles. If I have no insurance, I understand that the fees charged to me are my responsibility.

If I have been injured at work or in an accident, I am responsible to provide Alliance Health with the necessary Worker's Compensation or Auto Insurance billing information so that Alliance Health can bill the appropriate responsible party.

Acknowledgment

My signature indicates that I have read and understand all of the information above and on page one of this form. I understand that:

- My initial assessment does not guarantee enrollment into Alliance Health's Behavioral Health Program and if I am admitted, I will be limited to short-term, brief interventions up to 10 sessions.
- I consent to Alliance Health's retrieval of my prescription history by electronic inquiry through the Michigan Automated Prescription Systems (MAPS).
- The demographic, billing, and insurance information I have provided to Alliance Health is correct. I know it is my responsibility to provide up to date information at every visit.
- I am responsible to pay any copays, coinsurances, deductibles, or other costs related to my telehealth treatment, which may be due at the time of service.
- I have been given an opportunity to ask questions regarding my consent. All my questions have been answered.
- Alliance Health Behavioral Health primarily target's high risk patients by internal definition, but is open to all patients as availability allows. Eligibility in the program may change over time.
- If I need a higher level of care, I will be referred to another behavioral health provider in the community.
- Alliance Health will follow State & Federal laws in regard to protecting my medical and demographic information. My information is confidential, but my Behavioral Health Specialist will consult with my provider, his/her program supervisor, other members of my care team, and the consulting psychiatrist on an ongoing basis.

The signature below provides Consent for Telehealth Treatment. I fully understand that this consent is given in advance of a specific diagnosis or treatment. I am also aware that this consent will remain in effect until revoked in writing. My consent will be carried over to other Alliance Health locations should I choose another provider or service within this organization.

I am requesting treatment and given consent for treatment for (select one only):

Myself Patient Name (if patients guardian): ___________________________________

Documentation of relationship provided & scanned into chart:

Custodial Parent Legal Guardian License Court Appointed Other: _______________

Release of Health Information

Alliance Health may release health information (paper, electronic, x-ray, laps, etc.) to

- Other providers, pharmacies, or facilities that treat the patient to facilitate a continuum of care – including Alliance Health's consulting psychiatric oversight.
- The insured's insurance companies or agencies that Alliance Health uses for billing services.
- Companies that assist in improving the quality and efficiency of care at Alliance Health.

I consent to Alliance Health's retrieval of my Rx or prescription history by electronic inquiry.
If I cannot be reached by my home phone, a representative may give information about my (check all that apply)

☐ Test Results ☐ Diagnosis ☐ Care/Treatment ☐ Billing Statements

By the following:

☐ My Cell Phone

☐ Voicemail or e-mail as listed in demographics in Epic/MyChart

☐ My Spouse Name: ___________________________________ Phone: _________________

☐ My Children Name: ___________________________ Phone:_______________________

☐ Other: _______________________________________Phone:_______________________

☐ Do NOT provide information to anyone other than me ________ (initials)

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Signature of Patient Date

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Printed Name