ClearPath

CONSENT: INFORMATION-RECORDS-TREATMENT-FINANCIAL RESPONSIBILITY

Print Last Name, First Name, Middle Initial Date of Service

PLEASE READ THIS ENTIRE AUTHORIZATION BEFORE SIGNING

GENERAL CONTACT INFORMATION

Normal business hours are 8am-5pm, Monday thru Friday. You may contact our office during normal business hours at 615-447-9880. **Voicemail is not checked** and calls will not be returned after hours. If you are experiencing an emergency after normal business hours, please go to your nearest emergency room or dial 911 if your situation is life threatening. Counseling staff are available 24 hours a day for evaluation and assessment at TrustPoint Hospital by calling 615-848-5850.

GENERAL CONSENT FOR MEDICAL SERVICES

I request and authorize ClearPath Behavioral Health the ("Practice"), its agents and employees and my physicians, their associates and assistants ("Providers") who may attend to me during the outpatient visit to provide and perform such medical care, tests, procedures, drugs, and other services and supplies as are considered advisable by my provider for my health and well-being. I understand this may include, but is not necessarily limited to anesthesia, pathology, radiology services, and other special services and tests for communicable diseases, ordered by my provider. A provider will not be on-site 24 hours/day 7 days per week. A copy of this authorization shall be considered as effective and as valid as the original.

CONSENT FOR BLOOD-BORNE INFECTION DISEASE TESTING

I authorize the Practice to test for blood-borne infectious disease, including but not limited to hepatitis, Acquired Immune Deficiency Syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV") if a physician orders such test(s) or if ordered by protocol. The results of these tests will become part of my confidential medical record. Failure to consent to these tests will not result in denial of services.

☐ **YES.** I authorize the Practice to conduct blood-borne infectious disease testing.
☐ **NO.** I do not authorize the Practice to conduct blood-borne infectious disease testing.

RESCHEDULED, CANCELLED AND MISSED APPOINTMENTS

When you schedule an appointment with our office, that time is specifically for you. By making an appointment, you accept responsibility to pay the full fee for the professional time that is reserved for you. Our office has a policy of charging patients for the full cost of any appointment the patent fails to attend UNLESS THE APPOINTMENT IS CANCELLED AT LEAST 24 HOURS IN ADVANCE. To avoid charges, cancellations must be made by communicating to the office the patient's desire to cancel the appointment at least 24 hours in advance of the scheduled appointment time. This policy is strictly enforced unless prohibited by law. If you miss an appointment without notice, you will be charged the $150 for first visit or $75 for all other visits. Payment for missed visits is expected before rescheduling can take place.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and our Providers. In most situations we can only release information about your treatment to others if you sign a form that meets certain legal requirements imposed by HIPPA. There are some situations where we are legally obligated to take actions which we believe are necessary to attempt to protect you or others from harm and we may have to reveal some information about a client's treatment.

- If a client threatens to harm himself/herself we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- Child Abuse: If we have reason to believe that a child has been injured because of brutality, abuse, neglect, or has been sexually abused the law requires that we report this to Child Protective Services. Once a report is filed, we may be required to provide additional information.
- Adult and Domestic Abuse: If we have reason to suspect that an adult has suffered abuse, neglect, or exploitation the law requires that we report to the Department of Human Services. Once a report is filed, we may be required to provide additional information.
- Serious threat to health or safety: If a client communicates a threat of bodily harm against a clearly identified victim and we believe that the client has the ability and is likely to carry out the threat, we are required to take steps to protect the victim, including notifying the potential victim, notifying the police, or seeking hospitalization for the client.

If such a situation arises, we will limit our disclosure to what is necessary.

MEDICARE OR MEDICAID PATIENTS ONLY

I certify that the information given to me if applying for payment under Title XVII or Title XIX of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security Administration or its intermediaries, or carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services, or authorize such physicians or organization to submit a claim to Medicare or Medicaid on my behalf.

_____ MEDICAID PATIENTS ONLY: I understand that in the opinion of this Practice the services or items that I have requested to be provided to me may not be covered under the Tennessee Medicaid assistance program as being reasonable and medically necessary for my care. I understand that the Tennessee Department of Health or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items that I request and receive if there are services or items determined not to be reasonable and medically necessary for my care.

_____ MEDICARE PATIENTS ONLY: I acknowledge my receipt of the following written material of "Important Message from Medicare" – my initials acknowledge my receipt of this message from the Practice noted below and does not waive any of my rights to receive a review to make me liable for any payment.

COMMERCIAL INSURANCE PATIENTS

_____ COMMERCIAL INSURANCE: I acknowledge that I have carefully read the section in my insurance coverage booklets that describe mental health services. The Practice is required to provide a clinical diagnosis and is sometimes required to provide additional clinical information such as treatment plans, summaries, or copies of the entire clinical record to the insurance company. In such situations the Practice will release only the information about you that is necessary for the purpose requested. By signing this Consent, you agree that the Practice can personal health information to your carrier.

FINANCIAL CONSENT/ASSIGNMENT OF BENEFIT AND RELEASE OF INFORMATION

I hereby assign payment to (1) the Practice; (2) health care providers who are not employees of the Practice, but who have a contract with the Practice to provide services, such as Contract Physicians, Anesthesiologists, Radiologists, Pathologists, and Mental Health providers; and (3) health care providers who have no employment or other contractual agreement with the Practice, such as paramedics, and authorize them to release a copy of my medical records and release and any other information necessary for them to obtain payment from my insurance, Medicare, Medicaid, worker's compensation carriers, and Social Security Administrators with whom I have coverage or benefits that are, or may become, payable to me, including settlements or judgments from the incident for which I am receiving treatment. I acknowledge that the providers in categories two (2) and three (3) above are not employees or agents of the Practice and I understand that the Practice is not liable for the acts of the providers in categories two (2) and three (3). I agree to pay, when billed or requested by the Practice, any amount charged for Practice services not covered by the above payers.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

By signing this form you agree to abide by all the terms contained herein. You also agree to pay the Practice and the health care providers listed above all the charges promptly when due. ClearPath Behavioral Health provides two payment options for treatment. We offer a self-pay rate for patients without insurance benefit or who opt not to utilize their insurance benefits, or we will file claims with your insurance company for you. However, you will be responsible for paying any co-pays, deductibles, or fees for services not covered by your insurance. Payment is expected at the time of service, you will be asked to pay either the entire amount or an estimate based upon what we believe your insurance will reimburse. If your account is not paid timely, the Practice reserves the right to discontinue treatment until payment arrangements have been made. If your Practice account, or account with the health care providers listed above is forwarded to a collection agency or attorney: (1) whether or not legal proceedings are instituted, a collection agency fee not to exceed 20% of the account balance or One Thousand Dollars ($1,000), will be added to your account balance forwarded, and (2) you will be responsible for any court costs, reasonable attorney fees, and interest as allowed by Tennessee statute, incurred in the collection of your account.

Patients electing to either not utilize insurance benefits or without insurance are subject to prepayment for each service before services are rendered according to the following schedules:

CONSENT TO TREAT

Self-Pay Rates MD		Self-Pay Rates NPP		Self-Pay Rates Therapist	
Initial Visit	$300.00	Initial Visit	$225.00	Initial Visit	$175.00
Follow-Up and/or Med Check	$150.00	Follow-Up and/or Med Check	$100.00	Psychotherapy up to 60 min	$100.00
Psychotherapy 1 - 35 min	$175.00	Psychotherapy 1 - 35 min	$100.00	Family Session	$150.00
Psychotherapy 36 - 60 min	$300.00	Psychotherapy 36 - 60 min	$200.00		

I have been offered and/or received a written copy of my patient rights and responsibilities
☐ **YES** ☐ **NO**

I have received and/or been offered a copy of the Practice's Notice of Privacy Practice
☐ **YES** ☐ **NO**

I authorize the Practice to electronically obtain my medication history
☐ **YES** ☐ **NO**

I am seeking medical care/evaluation for disability determination
☐ **YES** ☐ **NO**

The undersigned agrees that he/she has read, understands, and agrees to pages 1, 2, and 3 of this consent form and any questions have been answered before signing.

Signature of Patient
(or Legal Representative if Patient Unable to Sign)

Relationship to Patient

Print Name

Date/Time

Signature of Witness

Date/Time

Signature of 2nd Witness
(if obtained via phone)

Date/Time

Address

Apt./Unit

City, State & Zip Code

Phone