

General Consent & Acknowledgement

Consent for Treatment

I hereby consent to receive behavioral health services through AMITA Health Alexian Brothers Behavioral Health Hospital (AHBHHHE) as provided by psychiatrists, psychologists, licensed clinical social workers, licensed clinical professional counselors and licensed nurses of AHBHHHE's Outpatient Group Practice.

I Authorize and request that AHBHHHE and my clinician(s) perform assessments, administer treatments and medications and obtain laboratory tests as they believe may be considered advisable in the diagnosis and treatment of my condition.

I realize that no particular outcome/result can be guaranteed as a result of my consent to treatment at AMITA Health Alexian Brothers Behavioral Health Hospital.

I hereby release any AHBHHHE Clinician from responsibility for any injury or other adverse outcome that results from my leaving AHBHHHE services against clinical and medical advice.

Patient Rights, Responsibilities and Notices

I acknowledge that I have received a copy of the following:

- | | | |
|--|------------------------------|-----------------------------|
| Patient Rights, Responsibilities & Confidentiality | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Notice of Privacy Practices | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Patient Advocacy Notice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

General Acknowledgements

- I expressly consent for AHBHHHE Outpatient Group Practice, its providers and agents to place calls to my cellular and/or residential phone using artificial or pre-recorded voice or auto-dialer technologies for any follow-up purposes: including billing and collections, for confirming appointments and/or information you request regarding treatment or medications.
- AHBHHHE Outpatient Group Practice may **not** leave a message on patients/family voicemail.

_____ I certify that it has been explained to me that by initialing here, I hereby give consent to be contacted by
Initials **Professional Research Consultants (PRC)** regarding the Outpatient treatment received. By leaving blank, I do not grant permission to be contacted.

Cancellation of Appointments

I agree that I will provide at least 24-hour notice to cancel a scheduled appointment. If I do not give proper notification, I understand that I am responsible for the late cancellation fee of \$55.00. I further acknowledge that my insurance cannot be billed for a late cancellation or failed appointment.

Release of Information for Processing Benefits

I hereby authorize AHBHHHE to release my diagnosis and necessary clinical records for the purpose of obtaining reimbursement/payment for treatment services provided directly to me or my dependents. Information may be released to any third party payor having responsibility for payment of charges for treatment including review agents, auditors, managed care and utilization review agents.

This consent is valid until such time that all claims have been settled to the satisfaction of AHBHHHE or up to one year from the date of discharge from AHBHHHE, whichever is longer.

I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize AHBHHHE to contact the actual or additional insured (e.g. my spouse) and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate this consent at any time before the expiration date so long as I submit my revocation in writing to the address listed below. Finally, the agency reviewing the clinical information and/or records will be advised not to re-disclose my records to any other agency/person without my written informed consent.

I understand that I am ultimately responsible for any and all charges not paid by my medical insurance, and that if I refuse to sign this Release of Information, I will likely have to pay for any and all charges incurred.

Assignment of Benefits

In consideration of services to be provided to me or my dependent, I hereby assign, transfer, and set over to ABBHH all of rights, title and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits. I understand that I am financially responsible to AHBHHHE for charges not covered by this assignment.

I certify that I am the patient and that I have received a copy of this form. If I am not the patient, I certify that I am duly authorized as the patient's general agent to execute the above and accept its terms.

_____	_____
Patient	Date
_____	_____
Person Authorized to Consent/Parent/Guardian	Date
_____	_____
Witness	Date
	Time

WHITE COPY – Chart YELLOW COPY- Office PINK COPY - Patient

Patient Name: _____

Account #: _____



AMITA HEALTH™

Alexian Brothers Behavioral Health Group Practice
 1786 Moon Lake Blvd.
 Hoffman Estates IL 60169

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Form # 6010-367 5/16

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