TREATMENT AUTHORIZATION AND PRIVACY ACKNOWLEDGMENT

Veridian Behavioral Health is here in referred to as "VBH".

1. **CONSENT FOR TREATMENT:** I consent to treatment or services provided by VBH professional providers. Further, I understand that among those who may provide services or treatment at VBH are medical, nursing and other health care personnel in training who may be present during patient care as part of their education. I understand that the practice of medicine and psychotherapy is not an exact science and acknowledge that no guarantees have been made to me as to the results of care, treatment, and the provision of medical services.

2. **AGREEMENT TO PAY FOR SERVICES:** I agree, whether I sign this as an agent or as the patient, that in consideration of services to be rendered to me, I hereby individually obligate myself to pay the charges of VBH in accordance with its regular rates and terms.

3. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign my insurance benefits other wise payable to me to be paid directly to VBH. I understand that I am financially responsible for charges not covered by this assignment and further agree to guarantee full payments of all charges not covered by third-party payers. If I do not pay the amount due as I agreed, I agree also to pay the reasonable costs of collection, including but not limited to attorney fees and collection agency fees.

4. **MEDICARE/MEDICAID/INSURANCE BENEFITS:** I authorize VBH to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers and to any peer review organization, any information needed for this or a related Medicare and/or Medicaid claim. I request payment of authorized benefits to be made on my behalf to VBH for services furnished to me, and to the providers involved for their services.

5. **AUTHORIZATION FOR DISCLOSURES TO REGULATORY OR OVERSIGHT BODIES AND WAIVER OF ACCOUNTING:** I understand that as part of its health care operations, VBH is required by law to disclose certain aspects of my protected health information to public health agencies, regulatory and oversight bodies. I hereby authorize VBH to make such disclosures without any accounting of such disclosures since they are required by law.

6. **PROVIDER NON-DISCRIMINATION ACT:** I understand that this is an equal opportunity institution. There is no discrimination because of race, color, religion, natural origin, age, sex, handicap, or inability to pay.

7. **PATIENT RIGHTS INFORMATION:** I have reviewed/received "Patient Rights and Responsibilities" and understand my rights as described in that document.

8. **NOTICE:** Your health information related to work-related illnesses or injuries or to medical surveillance of the workplace may be disclosed to your employer.

9. **CONSENT TO DISCLOSE GENERAL (APPOINTMENT) INFORMATION:** You may call me for appointment reminders or to reschedule appointments:

_____Do Not Call Me

_____Call Me At Home phone number_____

_____Call Me At Work phone number_____

_____Call My Cell Phone phone number_____

_____You May Give Appointment Information to my Spouse/Parents. (<u>If this is not okay you will not receive appointment reminders.</u>

10. **ACKNOWLEDGMENT OF RECEIPT OF NOTICES OF PRIVACY PRACTICES.** I hereby acknowledge that I have received a copy of VBH's Notice of Privacy Practices.

I certify that I have read and fully understand this document and that I have the right to receive a copy of it. I, as the patient/ personal representative, agree to sign this document indicating that I agree with all of its terms and statements.

_____ _____ _____

Patient/Personal Representative Signature Relationship to Patient Date

_____ _____

Witness Signature Date