**EDWIN FAIR COMMUNITY MENTAL HEALTH CENTER CLIENT AGREEMENT FORM**  **Consent for Evaluation, Treatment and Follow-up Policy on Confidentiality**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Chart Number

\_\_\_\_ New Admit

\_\_\_\_ Readmit

\_\_\_\_ Update

I give consent for

First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Maiden) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home (Cell) Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person and Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to be evaluated and/or treated at Edwin Fair Community Mental Health Center, Inc. I do \_\_\_\_ I do not \_\_\_\_ give permission for Edwin Fair Center to contact me for follow-up after treatment has ended. I understand that treatment will not be denied if I refuse follow-up contact.

I understand that strict confidentiality of all information will be maintained. Information will be released only with my written permission. I understand that my records are protected under State and Federal confidentiality laws and regulations and cannot be released without my written consent unless otherwise provided for in those laws and regulations. There are rare exceptions to this policy (e.g.., if a client expresses a serious intent to harm self or someone else, or if the Center is required by a court or by law to release information, as in a child abuse or child custody case, or if records are subject to review by Federal, State or local funding sources to verify and evaluate services delivered). I understand the above policies and will read the Clients Bill of Rights.

 **Financial Responsibility**

|  |  |  |  |
| --- | --- | --- | --- |
|  | % Assist | % Cost | Circle and/or list Payer Source |
| 1) Standard Fee |  |  | EFC DMH T19 Self |
| 2) Other Fee |  |  | Other Contract:  |

Edwin Fair Center charges a fee for services and I accept financial responsibility for the charges incurred. If I have insurance, I understand my assigned fee is still due for each visit. I understand that payment is due at the time of services. Any other arrangements must be approved in advance. I understand that Edwin Fair Center may use a collection agency to collect unpaid fees.

Family Yearly Gross Income\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reliable (Verified) \_\_\_\_ Estimated (Not Verified) \_\_\_\_\_\_

Number in Family Dependent on Above Income \_\_\_\_\_\_

 Income Source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Income Source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Remarks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assignment of Benefits/Release of Information** I assign and authorize direct payment of all benefits due for client services to Edwin Fair Center. A copy of the assignment may be used in lieu of the original. Edwin Fair Center may release information to the following to secure payment for services: Medicaid, Medicare, Insurance Co., EAP, etc…

**OHCA (T-19) and DMH #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medicare #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance Co.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I do not authorize Edwin Fair Center to bill the organization listed above, I will be responsible for the full fee for services. The information authorized for release may include information about communicable or venereal diseases which may include but are not limited to diseases such as hepatitis, syphilis, gonorrhea and other human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). ANY DISCLOSURE OF MEDICAL RECORD INFORMAITON BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.

|  |  |  |
| --- | --- | --- |
| **Signature** | **Relationship** | **Date** |

**If consumer is unable to sign for themselves, the form must be witnessed. Witness Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_

**EFC Staff** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_