

CONSENT—I request and voluntarily give consent to Oaklawn Psychiatric Center, Inc. (Oaklawn) and its clinicians who may attend me during this present period of care (as well as their associates, assistants, agents, employees and students) to provide and perform evaluation, treatment and ancillary services as identified in my plan of care. I recognize that Oaklawn uses qualified professionals to provide mental health services within the scope of their licensure/certification/ training or supervision.

I understand that I may request an explanation of the various steps and activities involved in receiving services and an opportunity to discuss risks, benefits, potential complications and alternative options at any time. I affirm that no guarantees have been made to me regarding the outcome of my care. I understand that I have the right to withdraw my consent at any time. I understand that a psychiatric assessment must be completed prior to discharge from inpatient services.

I agree that all rights and liabilities of each party, with respect to my admission and requested services, are to be governed by the substantive laws of the State of Indiana.

CLIENT RIGHTS—I have received a copy of my Oaklawn client rights and a handbook for intensive services.

NOTICE OF PRIVACY PRACTICES—I have received a copy of Oaklawn’s Notice of Privacy Practices, outlining my rights and Oaklawn’s responsibilities.

RELEASE OF INFORMATION—I understand that Oaklawn will release any and all information regarding diagnosis, treatment and prognosis with respect to any physical or psychiatric condition for which I am being treated—including treatment for alcohol/drug abuse or communicable disease(s)—to the following:

- To any party upon my written request.
- To any insurance company, employer, sponsored payer and/or third-party payer or representative providing coverage for this admission to confirm eligibility or authorize payment.
- To other healthcare providers concerned with my continuing healthcare, except as prohibited under 42 CFR, relating to drug and alcohol treatment records.
- To auditors to the extent necessary to conduct outcome studies; obtain/maintain licensure, certification accreditation; and/or access federal/state reimbursement.
- To first responders and medical providers in the event of a life-threatening emergency.
- To law enforcement in the event of a crime committed on Oaklawn property or against Oaklawn staff, and as required under federal security regulations.
- To Child/Adult Protective Services in the event of suspected abuse/neglect of a child or dependent adult.

AGREEMENT AND GUARANTEE TO PAY FOR SERVICES—I agree to pay for services provided by Oaklawn. I understand that all services are to be paid for when received unless other arrangements have been authorized by Oaklawn. I understand that therapy services may at times include collaboration and communication outside the therapy session. When these services exceed 15 minutes they may be billed separately. I agree to pay all fees not covered by my insurance, including deductibles, copayments and non-covered charges. I understand that I may be charged a fee if I fail to cancel a scheduled appointment at least 24-hours in advance. I understand that if I qualify for a fee subsidy through the Indiana Division of Mental Health, the adjustment will be applied only after all other insurance and payment sources have been exhausted, and may not apply to all services.

In the event that I fail to make timely payments, I understand that Oaklawn may turn the account over to an attorney or collection agency and I will be responsible for any collection-related fees in addition to the amount due to Oaklawn.

ASSIGNMENT OF BENEFITS—I assign and authorize payment of any medical insurance benefits, including Medicare and Medicaid to Oaklawn. I certify that any third party payer information provided by me is correct.

SERVICES VIA TELEMEDICINE—I recognize that some services are provided via telemedicine, which involves using electronic communications to enable a mental health provider at one location to serve an individual at another. Oaklawn’s goal in using telemedicine is to improve access to providers, leading to more effective and efficient care. Telemedicine equipment has security protocols to protect the confidentiality of the client’s identity and protected health information, and measures to safeguard against data corruption. In addition to risks associated with any clinical service, telemedicine includes the risk of a mistake or delay due to equipment malfunction, poor image quality or loss of access to records; or security failure causing an unintentional privacy breach. It is expected that the benefits of telemedicine will far outweigh any increased risk of harm. I understand that I may opt out of this treatment method without affecting my access to future services.

By signing below, I affirm that I have read and understand this document, and give my informed consent to receive care, treatment, and services at Oaklawn. My client rights have been verbally explained to me.



Client Signature _____ Date: _____

Parent/ Authorized Party: Signature _____ Printed Name: _____

Witness _____

White – Chart copy Yellow – Client copy

Form No. 35 Rev. 6/19

<p>Name: _____</p> <p>Client ID: _____ DOB: _____</p> <p>Oaklawn Psychiatric Center CONSENT FOR SERVICES</p>	 <p>* C O N S E N T S E R V I C E S *</p>	
<p>Client ID _____</p>	<p>Document Date _____</p>	 <p>* B U S I N E S S *</p>

CLIENT RIGHTS

As a patient or client of Oaklawn, you have the following rights. For minors, some rights are determined by the parent or legal guardian.

1. To accept or refuse treatment (unless ordered by a court) to the extent permitted by law.
2. To receive treatment within the least restrictive environment possible.
3. To receive humane care and treatment provided with dignity and respect, and protection from harm.
4. To have equal access to treatment regardless of race, religion, gender, ethnicity, age, handicap or sexual preference.
5. To practice your own personal religion.
6. To actively participate in planning for treatment (if over 12 years of age), with periodic opportunities for review.
7. To be given a full explanation of the nature of the treatment or habilitation program proposed for you, as well as alternative treatments or programs, if any.
8. To receive a clear description of the known effects of receiving and not receiving the treatment or services.
9. To formulate advance directives, including psychiatric advance directives, and appoint a surrogate to make health care decisions on your behalf to the extent permitted by law.
10. To receive services from competent, professional staff.
11. To contact or consult with legal counsel and private practitioners of your choice at your own expense.
12. To the confidentiality of all patient records (as defined by state and federal law).

We want to serve you in the best way we can. If you or family members have a concern or compliment about your care or safety at Oaklawn, please let us know by addressing it with your treatment team or by completing the "How Are We Doing" form located in the lobby. You may also contact the Client Advocate at 574-533-1234 ext. 4270.

The Indiana Division of Mental Health and Addiction in Indianapolis offers a Consumer Service Line for public mental health or addictions services in Indiana. They welcome your compliments, questions or concerns about the service you received at Oaklawn at 1-800-901-1133.

You may also contact the organization that accredits our services, The Joint Commission, by phone at 1-800-994-6610 or by e-mail at complaint@jointcommission.org.

You are also welcome to contact the Indiana Protection and Advocacy Services by calling 317-722-5555, or 800-622-4845.