Consent for Services

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

Name:

Client ID: DOB:

Oaklawn Psychiatric Center
CONSENT FOR SERVICES

CONSENT SERVICES

Client ID	Document Date

BUSINESS