VOLUNTEER BEHAVIORAL HEALTH CARE SYSTEM
PERMISSION TO TREAT/ORIENTATION/FEE FORM

I give permission for staff of Volunteer Behavioral Health Care System to provide any clinically necessary mental health services and to perform such diagnostic and treatment procedures deemed professionally and medically necessary in the care, treatment and management of my case.

Please place your initials (where applicable) in the box below indicating you have been informed of:

Initials ***CONFIDENTIALITY***

_____ *I may sign a release of information to anyone at any time I so choose to disclose certain mental health information about myself.*

_____ *Volunteer Behavioral Health Care System creates and maintains my PHI (personal health information) in an electronic format. VBHCS also communicates and transmits my PHI through different types of secure electronic communication systems.*

_____ *VBHCS only allows staff to review your PHI on a "need to know" basis. You may request us to "block" your PHI from certain staff (i.e. VBHCS employee that is family or friend, etc.).*

_____ *VBHCS allows routine non-clinical information to be communicated to you via text, phone, or email. We need to know your preference of communication. If you would like communication via phone, text, or email please provide the following:*

Cell Phone Text: #: ____

Cell Phone Call: #: ____

Home/Land Line #: ____

Email Address: ____

CLIENT RIGHTS

_____ I acknowledge receipt of the CLIENT RIGHTS AND RESPONSIBILITIES, which includes Crisis contact information, we do not use restraints and/or seclusion; and receipt of HIPAA Notice of Privacy Practices.

_____ If a TennCare eligible client under the age of 21, I acknowledge receipt of EPSDT/TENNderCare information, which includes the benefits of preventive healthcare, services available under TENNderCare and how to obtain those services, that services are provided at no cost to the client, and that necessary transportation and scheduling assistance is available upon request.

LEGAL

_____ *I understand that Volunteer Behavioral Health Care System does not discriminate on the basis of race, sex, age, national origin, handicap, or religion and that I am entitled to a grievance procedure should I have a complaint(s) regarding personal treatment discrimination. (Title VI – Section 504).*

_____ *Entering into a personal relationship including one of a sexual nature with a treating professional could be detrimental to the treatment process and my general well-being.*

DECLARATION OF MENTAL HEALTH TREATMENT

_____ I have been given information about a Declaration for Mental Health Treatment. I will review this information and if I choose to complete one, I can request a copy of the Declaration for Mental Health Treatment form at any time. I can also request assistance if I have questions regarding the Declaration of Mental Health Treatment.

_____ I do have a Declaration of Mental Health Treatment and will provide VBHCS with a copy.

Name: ____ Medical Record #_______________

PCP/PRIMARY CARE/OTHER PROVIDER COMMUNICATION
(PLEASE ONLY CHOOSE ONE OPTION)

_____ *I have been informed that open communication between treating clinicians is important; and lack of communication is counter-therapeutic and is potentially dangerous.* ***By completing a Release of Information, I am giving you my permission to communicate with my Primary Care Provider***.

_____ *I elect not to release any confidential mental health information to my* ***Primary Care/Other Provider*** *at this time and I also understand that my confidentiality rights may be waived in the event of medical or psychiatric emergency as required by law. I also understand that at any time I may choose to sign a release of information to disclose my mental health information as a way to better coordinate my healthcare services.*

_____ *I do not have a Primary Care Physician and I have been informed of the importance of receiving Medical care but do not wish to see a primary care physician at this time.*

_____ *I do not have a primary care physician but would like to have assistance in finding one.*

ORIENTATION

_____ *A map outlining the locations of building Entrances, EXITS, Fire Suppression Equipment, and First Aid Kits has been offered, and I have been given the opportunity to discuss any concerns.*

Tennessee Health Link

_____ *I am CHOOSING TO PARTICIPATE in Volunteer's Health Link program. Under the Health Link Program, I am CHOOSING TO PARTICIPATE IN THE Care Coordination Services. By Participating in Volunteer's Health Link Program my care manager may speak with my family members, my physical health provider, or others who are participating in my care that I have authorized by signing a written release of information.*

FISCAL

_____ *I authorize the release of information to my insurance company, Medicare, TennCare/TennCare Partners, and/or State of Tennessee agencies as requested and understand that this information may be used to monitor the quality of and medical necessity of the treatment that I am receiving. I understand that this information may include clinical case notes, treatment plans and diagnostic information such as DSM diagnoses. I authorize VBHCS to file my medical insurance and to release any medical information necessary to process my claims and insurance benefits to this facility. I also authorize this facility to exchange information with laboratory services when necessary.*

FEES*: VBHCS offers treatment at fees based on the cost of services. Your fee is expected at time of service. This agency accepts Medicare, TennCare, Insurance, and other third-party payers. If services are not covered by other payers, fees may be contracted. Payment plans may be arranged by calling (888) 756-2740 option 3 or (877) 567-6051. Due to constant demand for services, a 24-hour notice is expected for all cancellations. Charges may be incurred for cancellations without notice.*

_____ *I accept responsibility for my fees and I understand VBHCS does not guarantee copay and deductible amounts quoted by other payers. I understand that I am financially responsible for charges and for any balance not paid by my insurance company. Should my account require collection assistance at any time, I agree to pay all collection costs including attorney fees and contingent fees to collection agencies.*

This agency accepts payment by cash, check, or credit card. ***If you would like a copy of your charges regarding services, please let the receptionist know, and you will be provided a copy***.

My signature below indicates I have read, understand and agree with ALL of the above items and consent where applicable.

Client Signature ____________________ Date: ____________

Printed Name ____________________ Date of Birth __/__/____ Social Security #: ___-__-____

Parent/Guardian ____________________ Date: ____________
(Authorized Representative is required if client is either under the age of 16 or has a guardian appointed by the court. Clients 16 and older must sign form in addition to having legal guardian/Conservator/Custodian sign for the financial portion.)

Witnessed By: ____________________ Date: ____________

Name: ____________________ Medical Record #____________