VOLUNTEER BEHAVIORAL HEALTH

PERMISSION TO TREAT / ORIENTATION / FEE FORM

## Session Information

**Client:**

**Staff:**

**Document Date:**

**Client Program:**

# PERMISSION TO TREAT / ORIENTATION / FEE FORM PAGE 1

I authorize the staff of VBHCS to provide any clinically necessary mental health services and to perform diagnostic and treatment procedures deemed essential for the care and management of my case.

Please check the box (where applicable) below indicating you have been informed of:

| CLIENT RIGHTS | |
|---|---|
| | I acknowledge receipt of the Clients' Rights & Responsibilities, which includes information on crisis contacts, written notice regarding VBHCS's use of restraints and/or seclusion, and the HIPAA Notice of Privacy Practices.<br><br>This information can also be found by visiting our website at https://volunteerbehavioralhealth.org/privacy-policy/ |

| LEGAL | |
|---|---|
| | I understand that VBHCS complies with Title VI - Section 504, upholds a non-discrimination policy covering all relevant personal characteristics, and provides a grievance procedure for addressing any related concerns. |
| | I understand that entering 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. |
| | I understand that certain services are provided by unlicensed staff under licensed supervision, with all record reviews conducted in accordance with HIPAA regulations. |

| PRIVACY OF YOUR SUBSTANCE USE TREATMENT RECORDS | |
|---|---|
| | If you have substance use treatment records they are protected by federal law, including 42 CFR Part 2, HIPAA, and state privacy laws. These laws are in place to keep your information private.<br><br>This means your records cannot be shared without your written permission, unless the law allows it. |
| | By signing this Permission to Treat form, you are allowing VBHCS to share your protected substance use treatment information for treatment, payment, and health care operations. |

| | |
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| | **This may include sharing information with:**<br>**Your VBHCS treatment team**<br>**Your health insurance plan or other third-party payers**<br>**The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS)**<br>**People or organizations that help operate or support these programs** |
| | **Your information will only be shared as needed for these purposes.** |
| | **If your information needs to be shared for any other reason, we will ask you to sign a separate consent form, unless the law allows the disclosure.**<br><br>**Federal law (42 CFR Part 2) strictly prohibits unauthorized use or disclosure of your substance use treatment records.** |

| **PHOTOGRAPHY** | |
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| | **I will allow Volunteer Behavioral Health Care System (VBH) to take my photograph for identification purposes in the electronic health record.** |

| **ORIENTATION** | |
|---|---|
| | **I have been shown 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.** |

| **FISCAL** | |
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| | **I authorize the release of information to my insurance company, Medicare, Tenncare / Tenncare Partners, and/or State of Tennessee agencies as needed to monitor the quality and medical necessity of my treatment. This may include clinical notes, treatment plans, and diagnostic information. I also authorize VBHCS to file insurance claims and release necessary medical information for claim processing, as well as exchange information with laboratory services when required.** |
| | **VBHCS charges fees based on the cost of services, with payment expected at the time of service. We accept Medicare, TennCare, insurance, and other third party payers. If services are not covered, fees may be negotiated. Payment plans are available by calling (888) 756-2740, option 3, or (877) 567-6051. A 24-hour notice is required for cancellations; charges may apply for cancellations without notice.** |
| | **I accept responsibility for my fees and understand that VBHCS does not guarantee copay or deductible amounts quoted by other payers. I am financially responsible for all charges and any balance not covered by my insurance. If my account requires collection assistance, I agree to pay all associated costs, including attorney and collection agency fees.** |
| | **This agency accepts payment by cash, check, or credit card. To request a copy of your charges, please inform the receptionist.** |
| | **VBHCS offers self-pay agreement forms which allows services to be provided without being filed through your insurance plan. I understand that if I choose to sign a self-pay agreement, I will be solely responsible for any fees and/or balance accrued for any services provided.** |
| | **By signing below, I acknowledge that I have read, understand, and agree to the above terms.**<br>***(An authorized representative is required for clients under 16 or those with a court- appointed guardian. Clients 16 and older must also sign for the financial portion.)*** |

# PERMISSION TO TREAT/ORIENTATION/FEE FORM PAGE 2

| CONFIDENTIALITY | |
|---|---|
| | 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. I may sign a release of information to anyone at any time I so choose to disclose certain mental health information about myself. |
| | If at any point you would like to block your record from certain staff members (i.e. VBHCS employee that is a family or friend, etc.) please contact the front desk staff at your outpatient location. |
| | By providing my phone number to Volunteer Behavioral Health, I agree and acknowledge that Volunteer Behavioral Health may send text messages to my wireless phone number for any purpose. Message and data rates may apply.<br><br>Message frequency will vary. You can STOP messaging by sending STOP, and get more help by sending HELP. You will also be able to Opt-out by contacting CA/ CS at 1-877-567-6051.<br><br>For more information on how your data will be handled please visit our website: https://volunteerbehavioralhealth.org/privacypolicy/ |

| Choose how you wish to receive communication, Please choose any/all of your preferences: | |
|---|---|
| If you check a box please provide your phone number and/or email: | |
| ☐ Cell Phone | Cell Phone #: |
| ☐ E-Mail | E-Mail Address: |
| ☐ Home Phone/Landline | Home Phone #: |

| DECLARATION FOR MENTAL HEALTH TREATMENT | |
|---|---|
| | I have been offered information about the Declaration for Mental Health Treatment. If I choose to complete one, I may request a copy at any time and seek assistance with any questions, ( https://www.tn.gov/behavioral-health/mhsalaw/dmht.html ).<br><br>If I already have a Declaration of Mental Health Treatment I will provide VBHCS a copy. |

| ADVANCE DIRECTIVE | | |
|---|---|---|
| | Advance directives provide a way for individuals to express their treatment preferences, ensuring their wishes are honored even if they are unable to make decisions themselves.<br><br>For information about Advance Directives, please visit the website below.<br>English: https://www.tn.gov/hfc/health-care-decision-making/advanced-directives-for-health-care-decision-making--english-.html<br>Spanish: https://www.tn.gov/hfc/health-care-decision-making/advanced-directives-for-health-care-decision-making-faq--spanish-.html | |
| Please check the box before *"I have"* or the box before *"I have not"* for all four statements: | | |
| ☐ I have | ☐ I have not | Signed an Advance Directive / Living Will. |
| ☐ I have | ☐ I have not | Appointed a durable power of attorney for health care purposes. |
| ☐ I have | ☐ I have not | Appointed a health care agent to make health care decisions for me. |
| ☐ I have | ☐ I have not | A court-appointed conservator to make health care decisions for me. |

| PCP / PRIMARY CARE / CARE COORDINATION / OTHER PROVIDER COMMUNICATION | |
|---|---|
| | I have been informed that open communication between treating clinicians is important, and lack of communication is counter-therapeutic and is potentially dangerous. |
| | 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 also understand that my confidentiality rights may be waived in the event of a medical or psychiatric emergency as required by law. |

| (PLEASE ONLY CHOOSE ONE OF THE FOUR OPTIONS) | |
|---|---|
| 1. | ☐ I elect not to release any confidential mental health information to my PCP at this time. |
| 2. | ☐ I do not have a Primary Care Physician. |
| 3. | ☐ I do not have a Primary Care Physician but would like to have assistance in finding one. |
| 4. | ☐ I have a PCP and would like to share my confidential health information by signing a release of information. |

| TENNESSEE HEALTH LINK / INTEGRATED CARE MODEL |
|---|
| Volunteer Behavioral Health endorses an integrated care approach as a best practice model. We therefore operate as a team of providers each addressing a specific area of need to help our clients meet their true recovery potential. The team of providers includes medical providers, therapists, LPNs and care managers. All components of care are essential to the overall recovery of our clients and work together to provide the best quality outcomes for our clients.<br><br>I understand I will be participating in the integrated care model (TENNESSEE HEALTH LINK) as research and data support that this approach provides the best possible overall health outcomes. 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. |

| TELEHEALTH CONSENT |
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| I understand that my services may be provided via telehealth, and I consent to receiving telehealth-based services. |

## Signatures

| Client Signature: |
|---|
| Enter Signatory: |
| (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.) |

| Guarantor Signature: |
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| Enter Signatory: |

| Staff Signature: |
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| Staff Name: |

*Form # 153 (Rev. 9/2022; 6/2024, 11/2024 8/2026)*