

VOLUNTEER BEHAVIORAL
HEALTH CARE SYSTEM -
Permission To Treat

Session Information

Client: _____ 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.

"By signing below, I acknowledge that I have read, understand, and voluntarily agree to all policies, terms, and consent authorizations outlined in every section of this document. I confirm that I have had the opportunity to ask questions and that all my questions have been answered to my satisfaction."

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.

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.

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.

This may include sharing information with:

Your VBHCS treatment team

Your health insurance plan or other third-party payers

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS)

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.

Federal law (42 CFR Part 2) strictly prohibits unauthorized use or disclosure of your substance use treatment records.

PHOTOGRAPHY

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

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.

(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 choose to disclose certain mental health information about myself. I also understand that I must consent to the release of my substance use records on a separate document except as stated in the above Privacy of your Substance Use Treatment Records section.

If at any point you would like 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.

Please choose how you wish to receive communication:

**Communication
formats:**

☐ Cell Phone

☐ E-Mail

☐ Home Phone/Landline

Email:

E-Mail Address

Cell Phone:

Home Phone:

**VOLUNTEER BEHAVIORAL
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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. 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. For more information on how your data will be handled please visit our website: <https://volunteerbehavioralhealth.org/privacy-policy/>

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/mhsa-law/dmht.html>. 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.

For information about Advance Directives, please visit the website below. (<https://www.tn.gov/health/health-program-areas/health-professional-boards/hcf-board/hcf-board/advance-directives.html>)

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.	☐ I have	☐ I have not

**PCP / PRIMARY CARE / CARE COORDINATION / 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. 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.

- ☐ I elect not to release any confidential mental health information to my PCP at this time.
- ☐ I do not have a Primary Care Physician.
- ☐ I do not have a primary care physician but would like to have assistance in finding one.



I have a PCP and would like to share my confidential health information by signing a release of information.

**VOLUNTEER BEHAVIORAL
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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.

I understand I will be participating in the integrated care model (TENNESSEE HEALTH LINK) as research and data support this approach to provide 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

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

Acknowledgment of Artificial Intelligence (AI) Assisted Documentation

I understand and acknowledge that Volunteer Behavioral Health may utilize secure, HIPAA-compliant Artificial Intelligence (AI) technology "Within the clinical documentation process to assist clinicians during or after care sessions. By signing below, I understand that:

1. Purpose: AI tools are used strictly to assist with administrative, transcribing, and documentation processes so that my clinician can focus on our session.
2. Provider Supervision: AI tools do not provide medical or mental health advice, diagnostic conclusions, or therapeutic interventions. My provider maintains sole responsibility for all clinical decisions and final documentation.
3. Data Security: My personal health information (PHI) remains confidential, secure, and protected under HIPAA and applicable state laws.
4. Voluntary Participation: My consent to the use of AI tools in my care is voluntary. I may discuss any questions or request changes regarding AI usage with my provider at any time.

Signatures

Printed Client Name:

Client Signatures:

Guarantor Signature:
(if applicable)

Authority:

Employee/Witness Printed Name:

Employee/Witness Signature: