Clarity Healthcare

Consent to Treat

CLIENT NAME: (please print)_____

The below statements apply to all health care providers providing services through Preferred Family Healthcare, Inc. They include services provided by employees, contractors, agencies or other entities affiliated with Preferred Family Healthcare, Inc.

Please read each statement carefully. Sign and date the form at the bottom of the page. Be sure that you understand each statement; we will be glad to answer any questions that you may have if you do not understand their meaning.

I acknowledge that I received a copy of the Notice of Privacy Practices.

Dependent of the program you are admitted, programming may consist of recreation and physical exercise. I consent to participate in these activities, with participation being at my own risk and understand that Preferred Family Healthcare and its representatives shall not be liable for any claims arising out of participation. If there is a reason I cannot participate, I understand it is my responsibility to notify program staff.

I authorize the release of medical and billing information from Preferred Family Healthcare, Inc. records for the purpose of payment collection; including the release of alcohol or drug abuse (if applicable) information that may be contained in the records. Authorization includes the release of preadmission, recertification, and appeal information to insurance companies or their agents which may include diagnosis, symptoms, treatment plans, test results, or consultations. I further authorize the release of DMH69 Standard Means and DMH 8004 Notice of Cost information for the purpose of collection (if applicable).

Per regulatory requirements, a copy of the independent audit report of Preferred Family Healthcare, Inc. is available for review upon request.

I understand my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand the above consents are subject to revocation by me at any time, except to the extent action has been taken in reliance on this consent. This consent will stay in effect until account is settled.

Medical and Psychiatric Advanced Directives:

I consent to allow Preferred Family Healthcare, Inc. to obtain emergency medical or psychiatric treatment and/or medical services deemed necessary for my physical and mental health unless otherwise specified through written consent. I understand that I will be responsible for payments not covered under insurance benefits for these services. I also give permission to Preferred Family Healthcare and other healthcare entities of which I receive services to share necessary medical information for purposes of my healthcare and payment purposes.

I also consent to allow Preferred Family Healthcare to report communicable diseases as outlined by the Missouri Dept. of Health and Senior Services to that agency and to cooperate with investigations, providing client information as requested.

I have read and understand the above statements, and I understand that my signature pertains to each of them. I have also reviewed the information on the client registration form, and I confirm the accuracy of the information. I understand that refusing to sign this consent will result in not being admitted for services.

Would you like a copy of this authorization?

Please initial: ( ) YES ( ) NO

If yes, copies will be mailed to you if not provided immediately.

Client Signature:_____ Date: _____

Parent/Legal Guardian/Other (specify):_____ Date:_____