Clear Form

Consent for Services

Statement on Consent for Services for Electronic Signature with Andrews Center (AC)

I have received all of the materials checked below and am able to request this consent and ask questions about these documents at any time.
This consent shall remain effective only so long as is necessary to fulfill its purpose, but no later than Twelve (12) Months from the original date of signing unless previously revoked.

My consent is freely given and I understand that it may be withdrawn at any time with the exception of any action that has already been taken.

☐ **Notice of HIPAA Privacy Practices** - A description of how medical information about me may be used and disclosed and how to get access to my information.

☐ **Your Rights and Responsibilities of People Served Handout (Handbook)** - A description of rights and responsibilities for those receiving services. Also an explanation of the benefits, risks of treatment and how to file a complaint/grievances.

☐ **Understanding Fees for Services** - A description of my financial responsibility for services and the ability to complete a financial intake in order to determine how fees may be adjusted based on healthcare plans and when the sliding fee scale may be applied.

☐ **Telehealth Consultation** - I have been asked by my health care provide to take part in a telehealth consultation. This will be done with AC. The purpose is to assess my medical condition. This is done through a two-way audio/video link up with a health care provider.
I understand that :

1. I, my health care provider, or both of us will talk through the audio/video link with the health care provider.
2. I can ask that the exam and/or audio/video link be stopped at any time.
3. This procedure done through a two-way audio/video link will be equal to a face-to-face visit with a health care provider.
   This audio video link is conducted through the Internet with appropriate security and encryption technologies.
4. There are possible risks with the use of this new technology. Included but not limited to:
   - Interruption or disconnection of the audio/video link.
   - A picture that is not clear enough to meet the needs of the consultation.

   If any of these risks occur, the procedure might need to be stopped.
5. I authorize the release of any relevant medical information that pertains to me to the health care provider at AC or their
   agents. Information may include my name, age, birth date, or other information necessary to conduct this telehealth consultation.
6. This consultation will become part of my medical record kept by AC.

☐ **Mental Health Treatment Acknowledgment** - I hereby consent to screening, treatment and/or referral for my mental health and/or substance abuse concerns. I understand that these services may be provided by social workers, psychologists, and other mental health and substance abuse professionals. I understand that the information provided above and in the treatment is confidential and can only be released as is allowed by law and/or by permission, which I can withdraw at any time. (Note: AC is required to submit certain statistical information data to the Texas Department of State Health Services).

☐ **Crisis Services** - Information provided about triage, screening and referral processes.

☐ **Notice of Declaration for Mental Health Treatment** - Information provided about how to pursue obtaining this declaration.

☐ **Financial Consent for Disclosure of Confidential Information** I authorize AC to disclose to or receive from the following agencies, organizations, and named person(s) any and all records, **including alcohol/drug treatment and HIV status,** if applicable, for the purpose of obtaining financial information, including verification of income, to establish charges for services provided; to determine benefits eligibility; and, to file/pursue insurance claims for services received by the individual named. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. However, I understand failure to provide consent will result in my being responsible for payment.

☐ **Assignment of Insurance Benefits**
I irrevocably transfer and assign to the above provider all right, title, and interest in any payments due from all sources for services received.
Written assignment of insurance benefits is required for payment to be made directly to the provider.

- ☐ **LTSS/BIP Attestation** - The information on this financial statement is true and correct to the best of my knowledge. I will inform AC of any changes in my income or household. I have received a copy of the Fee Schedule and the informational brochure. I hereby authorize AC to disclose information for the purpose of obtaining financial information to establish and collect charges for services provided, to determine benefits eligibility and to file/pursue insurance claims for services received. I agree to pay all fees as assessed by the Business Office of the AC. I further understand that I may be discharged from services if I do not pay this account and assessed fees as they come due. I acknowledge that my information may be shared with other Texas Health and Human Service agencies to screen for other services for which I may be eligible. I understand that I will have the opportunity to decline to have my assessment information shared for this purpose.
- ☐ **Benefits Eligibility Section** - I acknowledge that my financial assessment will be used to screen my eligibility for benefits programs such as disability and/or Medicaid. If my financial assessment indicates I might qualify for a benefit program I will work with the benefits eligibility department of the AC to complete the application process. This could include providing documentation, attending appointments, or attending administrative hearings.
- ☐ **Financial Hardship** - I can claim a financial hardship when a significant financial change has occurred such as a reduction in income due to job loss, injury, hospitalization, etc. or the loss of health plan coverage or an increase in extraordinary expenses. I must provide written documentation to the AC to validate and be considered for the financial hardship.
- ☐ **PAP/Financial Assessment** - I understand that the AC has limited funds to pay for medications if I do not have Medicare, Medicaid, or insurance coverage. I will provide the AC with any needed documentation so they can assist me in applying for the Patient Assistance Program (PAP) in order to receive my medications for no charge. If I choose not to provide needed documentation or not to participate in the PAP program, I will be put on a waiting list for the center to pay for my medications.

Client Signature_____ Date_____

Staff Signature_____ Date_____