FINANCIAL POLICY
CONSENT FOR OUTPATIENT TREATMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES

FINANCIAL POLICY

Compliance with your financial obligation is considered a part of your treatment. Forest View Medication Management Clinic will do its best to obtain benefit information about your insurance coverage, including anticipated co-pays and deductibles. It is your responsibility to provide the Clinic with current demographic and insurance information. Failure to do so may result in non-payment of your claims, which may become your responsibility for payment. The Clinic will submit claims to your insurance company on your behalf. Forest View Medication Management Clinic contracts with an outside agency for claims submission and payment of physician billing. A statement will be mailed to you after your insurance company has responded to your claim. Payments must be made promptly. Your insurance policy is a contract between you and your insurance company; the Clinic is not a party to that contract. It is your responsibility to understand your benefits and limitations, including your clinician's participation status, and to obtain authorization for services when required by your insurance company. Authorizations are not a guarantee of payment and any disputes or questions regarding your bill should be made directly and promptly to your insurance company.

Failure to comply with the Financial Policy may result in closure of your case.

- I understand that if I/ the client fails to show for the scheduled appointment time, I will be charged $50, unless I cancel at least 24 hours in advance. I will be responsible to pay this prior to the next appointment.
- I understand that treatment may be discontinued if I fail to make payments in a timely manner, and that it is my responsibility to set up payment arrangements with Forest View, if needed.
- Any anticipated co-pays and deductibles MUST be paid at time of service
- Fees for other services (reports, copies, etc.) are not an insurance benefit, and will be your responsibility for payment.

INITIALS:_____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize Forest View Medication Management Clinic to submit claims on my behalf, and authorize payment directly to Forest View Medication Management Clinic for services rendered. I hereby authorize release of information from my medical record regarding these services to my Insurance Company(s), or designated agency, for the authorization of this service. I understand that this information may be verbal or written. I understand the information to be disclosed may include treatment of Psychiatric, Substance Abuse, and/or HIV/AIDS related illnesses and therefore is protected by Federal regulations and requires my written authorization to be released. INITIALS:_____

CONSENT FOR TREATMENT

About My Treatment

- I, the undersigned, am voluntarily consenting to outpatient treatment at the Forest View Medication Management Clinic for the client named below. I understand that I may withdraw my consent in writing at any time. I understand that no guarantees have been made to me about the results of treatment.
- I understand that I am responsible to contact the clinician if there are any significant changes in the client's physical or mental condition.
- I understand that if I/the client fails to attend two or more of his/her appointments without canceling 24 hours in advance, Forest View Medication Management Clinic will consider this non-adherence to treatment and may close the client's case.
- I understand that the client must be present at each appointment, and minors should be accompanied by a parent/guardian.
- I understand that it is my responsibility to plan ahead when needing refills. Refill requests take 2-3 business days to be processed.

Confidentiality

I understand that the Forest View Medication Management Clinic will maintain confidentiality of the client's care.

Instances where confidentiality may be broken:

- Abuse/Neglect: I understand that healthcare professionals are required by law to report to the proper authorities any instance of neglect or abuse (suggested or otherwise) of a vulnerable (incompetent, mentally disabled or otherwise restricted) child or adult.
- Duty to Warn: I understand that healthcare professionals are required by law to report to the intended victim(s) and law enforcement if a client expresses clear intentions to harm self or others.
- Lab Testing: I understand and permit Forest View Medication Management Clinic to disclose my diagnosis for laboratory testing.
- Performance Improvement and Accreditation: I understand that Forest View Medication Management Clinic conducts its own performance improvement studies, and is periodically reviewed for accreditation purposes by external agencies. I understand that the client's treatment may be examined for this reason. INITIALS:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES (version 10403B)

I acknowledge that I have received the Agency's Notice of Privacy Practices. INITIALS: _____

I have reviewed the above, and have had the opportunity to have my questions answered.

Client Name (please print)	Client's Date of Birth
Client or Responsible Party Signature	Date
Witness	Date