

**Palmetto Behavioral Health Solutions
Acknowledgement and Consent**

Consent for Medical Treatment

I/we voluntarily consent to outpatient treatment provided by Palmetto Behavioral Health Solutions. I/we consent to the testing for drugs and alcohol if deemed advisable by my physician. I/we am/are aware that the practice of medicine is not an exact science and that no guarantees have been made as to the result of treatments or examinations. The undersigned authorizes Palmetto Behavioral Health Solutions, its staff, and attending physicians to render to the patient all customary care, therapy, treatment, tests and procedures considered advisable, including emergency treatment and transportation to another facility if necessary.

Authorization for Release of Information for Insurance Purposes and Assignment of Benefits

The staff of Palmetto Behavioral Health Solutions is authorized to release any medical information required in the processing of applications or submission of information for financial coverage, including information referring to psychiatric care, and drug and alcohol abuse provided during this treatment. I/we agree to the release of medical or other information about me to government regulatory agencies (federal or state) as required by law. For Medicare and/or Medicaid beneficiaries – I/we have provided all necessary information for proper assignment of Medicare and/or Medicaid benefits.

Agreement of Financial Responsibility

I/we guarantee payment of all charges associated with services received from Palmetto Behavioral Health Solutions. I/we agree to assign any insurance benefits or other funding to Palmetto Behavioral Health Solutions. I/we have read and understand my financial responsibilities as a patient of Palmetto Behavioral Health Solutions. I acknowledge my receipt of the financial policy for Palmetto Behavioral Health Solutions. _____ (initial here)

Drug and Alcohol Programs

I understand that this health information is protected under state and federal laws (45 CFR parts 160, 164; 42 CFR part 2; 42 USC 20 odd-3; 42 USC 290ee; SC Code Ann Section 19-11-95) and cannot be disclosed without my further written consent unless provided for by state and federal law.

Patient Rights

I acknowledge my receipt of “Your Individual Rights as a Client”. _____ (initial here)

H.I.P.A.A (Health Insurance Portability and Accountability Act) Notification

I acknowledge my receipt of Notice of Privacy Practices for Palmetto Behavioral Health Solutions. _____ (initial here)

I understand that the consent for medical treatment, authorization for release of information, assignment of insurance benefits and agreement of financial responsibility can only be revoked upon written notice. However, revocation of any of these documents may result in discontinuation of treatment. By signing below, I/we acknowledge that this consent form has been read in full and explained to me, as necessary.

Signature of Patient or Parent/Legal Guardian

Date

Signature of Witness

Date