GENERAL CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

CONSENT FOR TREATMENT

I give Porter-Starke Services, Inc. ("PSS") and Porter-Starke Services, Inc. dba Marram Health Center ("MHC") permission to provide the diagnostic and treatment procedures that are deemed necessary by its medical and/or clinical staff. I recognize that the practices of both the psychological, psychiatric, and medical professions are not exact sciences and, therefore, I acknowledge that no guarantees have been made, or can be made, concerning the likelihood of success or outcome of any examination, test, diagnosis, treatment or therapy performed by PSS/MHC and its employees and contract personnel.

INDIANA DIVISION OF MENTAL HEALTH AND ADDICTION (DMHA)

I authorize PSS to release information to the Indiana Division of Mental Health and Addiction (DMHA) if the requirements are met under the terms of the DMHA Supported Consumer guidelines for community mental health center clients. DMHA Supported Consumer program allows us to offer sliding fee scales to the uninsured that meet the state guidelines. For all individuals meeting the following enrollment criteria: eligible diagnosis, family income at or below 200% of the Federal Poverty level, State of Indiana resident, Food Stamp recipient, TANF recipient, and/or a Medicaid recipient an Adult Needs and Strengths Assessment (ANSA) or a Child and Adolescent Needs and Strengths Assessment (CANS) will be conducted at the onset of treatment and at regular intervals during the course of treatment by your primary clinician. As a consumer you have the right to refuse enrollment, and you may cease your enrollment at any time.

SERVICES VIA TELEHEALTH

I recognize that some services are or may be provided via telehealth, which involves using electronic communications to enable a health provider at a location to serve an individual at another. Telehealth increases access to providers and offers the opportunity for continuous care. Telehealth equipment has security protocols to protect the confidentiality of the client's identity and protected health information, and measures to safeguard against data corruption. In addition to risks associated with any clinical service, telehealth includes the risk of a mistake or delay due to equipment malfunction, poor image quality or loss of access to records, or security failure causing an unintentional privacy breach. It is expected that the benefits of telehealth will outweigh any increased risk. I understand that I may opt out of this treatment method without affecting my access to future services; I also understand that I have a choice to request telehealth or traditional in-person services. However, telehealth services may be the treatment method available during unforeseen or extreme circumstances (i.e. a public emergency) or may be the soonest types of services available. I understand that I will be asked to confirm my consent at each telehealth visit which includes my agreement that I have the necessary technology available to participate in a telehealth visit.

CONSENT FOR USE OF INFORMATION

By signing below, I give permission to PSS/MHC to send appointment reminders and emergency notifications via text or phone call. I recognize these are part of doing business and providing treatment. I consent to my photograph being taken for use in the electronic health record, to confirm my identity. I understand that PSS/MHC may securely use basic identifying information about me to access the Indiana Health Information Exchange (IHIE) CareWeb repository of healthcare data, which may contain information that may be beneficial to the provision of treatment at PSS/MHC.

SERVICE PROVISION

I recognize that provision of services is voluntary and I must adhere to the Client/Patient Rights and Responsibilities. Services are intended to be private and focused on treatment. I acknowledge by signing below that recording services without permission from PSS/MHC is counterproductive to treatment and thus not allowed by PSS/MHC unless written permission is given by the provider. I understand that noncompliance may result in termination of treatment with PSS/MHC.

PAYMENT TERMS AND ASSIGNMENT OF BENEFITS

- **Medicare**: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder from PSS, MHC, and/or the Inpatient Care Center of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I understand that I am responsible for the Part A and B Medicare deductibles, Medicare co-insurance and any personal charges incurred. I request that payment of authorized Medicare benefits be made on my

behalf for any services furnished to me by or in PSS/MHC, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I permit a carbon copy or photocopy of this authorization to be used in place of the original.

- **Medicaid**: I agree to pay the Medicaid co-pay amounts not paid by Medicaid.
- **Commercial Insurance**: I agree to pay the balance not covered by my insurance and I understand that amount is based on my plan type and benefit limitations. My Co-Insurance, Co-Pay and/or Deductible are due at time of service as estimated by the Client Financial Services Department. *Insurance companies do not guarantee payment.*
- If my insurance processes my claims and indicates that I owe more than was estimated, I will receive a monthly Statement that is payable upon receipt. I understand that other payment arrangements must be approved in writing, in advance, by PSS/MHC.
- In the event that this account is turned over for collection, I agree to pay any balance left due and owing, and I agree to pay all collection, interest, court cost and reasonable attorney fees, all without relief from valuation and appraisement laws.
- **Self-Pay:** If I am uninsured I may qualify for a discount based on my household income and number of dependents. Discounts are awarded by the information I give on the "Summary of Income" form. Fees will be reduced based on the current sliding fee scale and will be reviewed at least yearly (every 6 months for PSS clients and every year for MHC patients). The reduced payment is required at the time of service.
- Referrals to providers outside of PSS/MHC may be out of network with your health insurance company. Out of Network providers do not have to follow charge and payment arrangements that have been negotiated with your health insurance company. Therefore you may incur bills for services that exceed payment amounts that have been negotiated by your health insurance company. It is advisable that you contact your insurance company for information and assistance, including an in network provider list for this health care service.
- **I authorize and/or assign to PSS/MHC payment of government and/or third party medical benefits for services provided.**

Porter-Starke Services, **ICC Only:** □ **EDO** □ **Other Commitment** _____ □ **Voluntary**

RELEASE OF INFORMATION

I authorize PSS/MHC to release any medical or other information to Medicare, Medicaid, and/or any third-party payer as necessary for processing claims for payment for services provided. I understand information covered under 42 CFR part 2 will require an additional authorization to release information.

X_____ _____ _____

Client / Legal Guardian Signature **Printed Name of Person Signing** **Date**

_____ _____

Relationship to Client **Medical Record Number**

INFORMATION GIVEN TO CLIENT

Initial items 1 through 2.

1. _____ I have received a copy of the Client/Patient Rights and Responsibilities. (Attached)
2. _____ I have received a copy of the HIPAA Notice of Privacy Practices. (Attached)
3. _____ **ICC Only**: I have received a copy of the Client Handbook.
4. _____ **ICC Only**: I have received notice that a physician is not present on the Inpatient Care Center 24 hours per day, 7 days per week.

For Staff use only below this line **For Staff use only below this line** **For Staff use only below this line**

PORTER-STARKE SERVICES, INC/MARRAM HEALTH CENTER

CLIENT NAME: _____

Directions: Scan into Streamline under "Scanned Consent to Treat"
Form Name: **General Consent for Treatment & Financial Agreement**
Form Rev. Date 06-13-11, 04-04-14, 12-11-17, 4-26-18, 11-5-18, 6/11/2020, 6/22/2023, 7/5/2023