Vera French Community Mental Health Center

Patient Name:____ MRN: _____________

Statement of Patient Financial Responsibility

The service you have elected to participate in implies financial responsibility on your part. The responsibility obligates you to ensure full fee payment. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. You are required to provide us with a current copy of ALL insurance cards at EACH VISIT. Failure to do so may result in a balance that is your responsibility. To ensure accurate billing, it is crucial that you provide us with any changes including, but not limited to, your insurance coverage or policy, address, phone number, income and/or dependents. Many insurance companies have additional stipulations (non-covered services, etc.) that may affect your coverage, and you may be liable for these stipulations. If you are a resident of Scott County, you may be eligible for a sliding fee scale based on your income, number of dependents and legal settlement.

Statement of Assignment

If eligible for health insurance or sliding fee scale coverage, I understand Vera French Community Mental Health Center (VFCMHC) will submit claims for me. I authorize VFCMHC to receive payment of benefits for treatment provided, including those otherwise payable to me. I understand that I am financially responsible to VFCMHC for charges not covered by my insurance at the rate agreed upon. I also authorize VFCMHC to release my information required by my insurer or Scott County to pay benefits or fee subsidies for covered services rendered. If I am not eligible for sliding fee coverage, my information will not be disclosed to Scott County. This authorization shall remain in effect for as long as I receive services from VFCMHC. My signature on the document indicates that I understand and agree to the terms stated here. A fax or photocopy of this signed authorization is as valid as the original.

Note to Court Appointed Guardian/Healthcare POA: *Your signature on the above statements is needed for billing purposes. These signatures allow Vera French CMHC to bill the patient's insurance and to provide information to the insurance company or other payer in order to process claims, when needed. Court Appointed Guardians/Healthcare POAs are not held personally responsible for payment of services rendered but we may ask that you assist our billing office in making arrangements for payment on any balance not paid by the insurance company, using the patient's financial resources. If there is a Conservator or Financial POA involved, please provide us with that information so we may work with that person regarding payment for services.*

Vera French Community Mental Health Center

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that Vera French Community Mental Health Center (VFCMHC) has provided me with a copy of VFCMHC Notice of Privacy Practices. I understand this document provides an explanation of the ways in which my health information may be used or disclosed by VFCMHC and my rights with respect to my health information. I understand that I may request a new copy of this Notice of Privacy Practices at any time.

Acknowledgement of Receipt of Grievance/Appeals Process

I acknowledge that Vera French Community Mental Health Center (VFCMHC) has provided me with a copy of the Grievance and Appeals Process and I understand that I may use this process to express concerns, complaints, or grievances about any aspect of my care.

Acknowledgement of Receipt of Service Descriptions

I acknowledge that Vera French Community Mental Health Center (VFCMHC) has provided me with a list of service descriptions for all VFCMHC services. I understand that these descriptions include any services that I am receiving or may receive from VFCMHC.

Acknowledgement of Client Rights and Responsibilities

I acknowledge that Vera French Community Mental Health Center (VFCMHC) has provided me with a copy of the Client Rights and Responsibilities and understand that this document outlines that I will be treated with dignity and respect and other rights I have as a patient, and that it is important for me to be an active participant in my treatment. I understand and agree to my responsibilities as a client of Vera French Community Mental Health Center.

Acknowledgement of policy on confirming Psychiatric evaluation appointment:

I acknowledge that Vera French Community Mental Health Center (VFCMHC) has reviewed with me the policy on confirming psychiatric evaluation appointments. It is necessary for me to call and confirm my psychiatric evaluation two weeks prior to my appointment. Failure to do so will result in cancellation of the appointment and me not being able to reschedule that appointment for 6 months. I may continue therapy with any current providers during that time. I understand and agree to my responsibilities as a client of Vera French Community Mental Health Center.

Vera French Community Mental Health Center
Consent for Treatment

I understand that while psychotherapy and/or medication may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects. I am encouraged to discuss any such difficulties with my Vera French Community Mental Health Center (VFCMHC) provider.

Based on the information provided to me, I am making an informed decision to participate in outpatient diagnostic and treatment services at VFCMHC at this time. I understand that this consent will continue for the course of my services with Vera French and will expire upon my completion or termination of services. I understand that, in most circumstances, my participation in services is voluntary and I may terminate my services with Vera French at any time.

While at Vera French I understand that I will always be under the practice of a licensed Physician, Advanced Registered Nurse Practitioner or Therapist, and also may be treated by an Intern or Student.

I have read the above policy regarding my financial responsibility for services provided by Vera French Community Mental Health Center. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Vera French Community Mental Health Center. The remaining balance will be my sole responsibility.

My signature indicates that I have been given the above documents and given the opportunity to read these documents. In addition, I have been given an opportunity to ask and have any questions I may have answered.

____ ____________________
Printed Name of Patient Date of Birth

____ ____________________
Signature of Patient or Legal Representative Date

____
Printed Name of Legal Representative

____
If not patient, indicate legal relationship to patient

Guardianship Documents Obtained & Scanned: ________

Created: 11-2015 smp