GENERAL CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

CONSENT FOR TREATMENT

I give Porter-Starke Services, Inc. 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 and psychiatric 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 Porter-Starke Services, Inc. and its employees and contract personnel.

INDIANA DIVISION OF MENTAL HEALTH AND ADDICTION (DMHA)

I authorize Porter-Starke Services, Inc. to release information to the Indiana Division of Mental Health and Addiction (DMHA) if enrollment guidelines are met under the terms of the Hoosier Assurance Plan (HAP). HAP is what 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, *but failure to enroll in the HAP can result in possible loss of Medicaid benefits for certain services.*

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 of Porter-Starke Services, Inc. and 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 me by or in Porter-Starke Services, Inc. and the Inpatient Care Center, including physician 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 Spend down amount 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.
- I agree to pay the amount that I owe for services at the time of each visit. I understand that other payment arrangements must be approved in writing, in advance, by Porter-Starke Services, Inc.
- 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.
- I understand I will be charged $25 if I do not show for an outpatient appointment or if I cancel the appointment less than 24 hours before the appointment time. This fee is not covered by insurance.
- Based on my income and number of dependents, I can request a fee discount (if qualified). If I receive a Discount Request Notice based on the information provided, I understand that the discount is time limited and requires that I be registered in the Hoosier Assurance Plan. I understand that once my discount has ended, I will be responsible for the full fee for services.
- I authorize and/or assign to Porter-Starke Services, Inc. payment of government and /or third party medical benefits for services provided.

RELEASE OF INFORMATION

I authorize Porter-Starke Services, Inc. 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** **Relationship to client**

______________________________ ____________________

Staff Witness **Date**

INFORMATION GIVEN TO CLIENT

Initial items 1 through 2

1. ______ I have received a copy of the **Client Rights. (Attached)**

2. ______ I have received a copy of the **HIPAA Notice of Privacy Practices**. (Attached)

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

CLIENT NAME: ________________________________

CLIENT NUMBER: ______________________________

Directions: Scan into Accumed under “Consent to Treat” then send to HIM for final scanning into Mindlinc

P:/Forms current, HIM/General Consent to Treatment